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:	15 July 2021
Centre ID:	OSV-0003605
Fieldwork ID:	MON-0032928

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:	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
Thursday 15 July 2021	09:30hrs to 20:05hrs	Marie Byrne	Lead
Thursday 15 July 2021	09:30hrs to 20:05hrs	Erin Clarke	Support
Thursday 15 July 2021	09:30hrs to 20:05hrs	Valerie Power	Support

What residents told us and what inspectors observed

This risk based inspection was completed to verify the actions outlined by the provider in their plan following the last inspection in the designed centre in February 2021, and in a provider assurance report which had been issued to the provider in May 2021 following a trend of notifications relating to alleged psychological abuse. In addition, unsolicited information in the form of a concern had been submitted to the Chief Inspector of Social Services since the last inspection.

There were 14 residents living in centre on the day of inspection, and the inspectors had the opportunity to meet and briefly engage with each of them. There was a respite bed which had not been used since the start of the pandemic, and inspectors were informed by the management team that in line with two residents' changing needs there were no plans for new admissions at present.

Overall, the findings of this inspection were that the majority of residents were happy and felt safe in the centre; however, due to the persistent trend of psychological abuse this was not reflective of every residents' experience. While improvements were noted in relation to a number of the actions from the provider's plans as part of their national improvement plan and following the last inspection, there remained high levels of non compliance with the regulations.

Warm and respectful interactions were observed by inspectors between residents and staff throughout the inspection. Residents appeared comfortable with staff and a number of residents were very complimentary towards them. A number of staff spoke about the positive impact of core teams in the houses on continuity of care for residents, communication within teams, and on teamwork. A number of staff vacancies remained and the provider was recruiting to fill them, but as a result, there an over-reliance on agency staff.

There were volunteer co-workers in the centre, and a number of them were on holidays at the time of the inspection. Inspectors were informed that co-workers were additional to the staffing quota. A number of residents talked about how they enjoyed spending time with co-workers, with two residents talking about throwing the co-workers a going-away before they went on holidays.

Residents described activities they were regularly enjoying such as, gardening, cooking, horse riding, golf, cooking for their housemates, baking bread for the community, walking and art. Inspectors observed residents chatting with each other in different parts of their homes, spending time engaging in activities with staff, or sitting together enjoying a cup of tea. A number of residents showed inspectors around their home. They were very house proud and talked about talked about how important it was for them to do things for themselves, including taking responsibility for keeping their rooms and their home clean and tidy.

Some residents talked about the impact of the pandemic on their access to

activities, particularly those in the community and talked about how much they were looking to get back to regularly accessing their local community. They talked about things starting to get back to normal and about things they were looking forward to such as going to the hairdresser, going to the cinema, going to a hotel on holidays, and meeting their family and friends for a meal. One resident talked about the importance of supporting local businesses during the pandemic, such as buying vouchers for their family and friends from them. A number of residents spoke about their loved ones and important people in their lives such as their Camphill family and friends.

Staff were observed to be very familiar with residents communication preferences. For example, there was also a board in the kitchen with pictures two signs of the week, which were biscuit and tablet computer and a staff member was observed using the sign for biscuit to ask a resident did they want one and the resident nodded to them to indicate that they did.

Inspectors observed that each of the houses had a homely feel. There were a variety of personal photos, artwork, framed pictures and soft furnishings throughout the houses, some of which had been hand-made by the residents. In one of the houses there a large wall mural in the hallway depicting resident's artistic talents. The person in charge had highlighted several home improvements to the provider and these will be detailed later in the report.

In one of the houses visited the inspector was aware of verbal mocking incidents between two residents, and one resident had expressed dissatisfaction concerning this issue. The provider had notified the Chief Inspector of these incidents as required by the regulations. It had become apparent that the impact of these negative interactions was adversely affecting the quality of life for one of these residents. The resident informed the inspector that they were very happy living in the house. Still, due to the incidents with another resident, they did not always feel secure in their environment. This had resulted, on occasion, in them eating meals away from the kitchen and wanting to spend time outside the house. The provider had responded to these peer-to-peer incidents with additional supports such as, staffing supports, supporting one resident to go on a holiday, and the provision of private psychology input; however, the issue of the compatibility of some residents remained, and required intervention from the provider.

Residents were aware of the complaints process and a number of them told inspectors that they felt that their concerns were listened to by staff, and acted upon. A number of residents demonstrated a good awareness of the fire safety measures, with one resident showing an inspector what they would do in the event of a fire and proceeded to the emergency exit located on the first floor. Another resident talking about difficulties they had during recent fire drills and how this was being resolved.

Resident and family input was captured by the provider in the latest six monthly review in March 2021. Three residents' views and four residents' representatives views were captured. An inspector also had an opportunity to speak with a residents' representative on the phone during the inspection. Overall residents were

complimentary towards where they lived, who they shared their home with, the activities they engaged in and with the support they received from the staff team.

For the most part, residents' representatives were complimentary but some included areas where they had concerns or would like to see improvements in the centre. They described staff as kind, supportive, good, and caring and the atmosphere in the centre as fantastic. Each of them indicated that the provider had managed COVID-19 very well.

Some indicated they were worried about the turnover of staff. Some felt communication could be better and again felt that this may be due to staff changes. One representative raised concerns in relation to the implementation of the residents' guidelines and stated that the constant turnover of staff and the use of agency staff was not ensuring the consistent implementation of the residents' guidelines.

In summary, for the most part residents appeared comfortable and content in their homes. While some improvements were found during this inspection, there remained high levels of non compliance with the regulations.These areas for improvement will be detailed in the next two sections of the report as will the findings of this inspection 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 serious of poor inspection findings in centres operated by Camphill Communities of Ireland, the registered provider was required to submit a comprehensive national improvement plan to the Chief Inspector of Social Services. This centre was last inspected in February 2021 as part of this national monitoring programme of Camphill Communities of Ireland. During this inspection, the inspectors found that while there had been some improvements, the centre remained under resourced and this was still impacting on the provider's ability to bring about some of the planned improvements in the designated centre.

The inspectors found that that while improvements had been made in line with the actions outlined the providers national improvement plan and from the compliance plan following the last inspection, there remained high levels of non compliance with the regulations. Some of the changes that the provider had made were in their infancy and yet to fully impact on the safety, quality and standard of care delivery for residents. Some residents' assessments of need and personal plans were not found to be reviewed or reflective of their current care and support needs. In addition, the provider was not adequately protecting some residents from ongoing psychological abuse.

As a result of these findings of sustained levels of non compliance with the

regulations across a number of inspections, the provider was invited by the Chief Inspector to attend to a Provider Warning Meeting. The Chief Inspector required the provider to demonstrate that they would continue to complete the actions they had planned, build on improvements, and bring about improvements in the overall levels of compliance in order to demonstrate the provision of safe and quality care required for residents in this centre.

While changes to the governance arrangements had resulted in some improvements in relation to oversight of the services provided for residents in the centre, concerns remained in relation to, the staffing numbers and skill mix, the day-to-day oversight and monitoring of care and support for residents, residents' compatibility, safeguarding, residents' assessments and personal plans, and residents' access to allied health professionals. Inspectors viewed evidence that the provider had escalated concerns in relation to access supports from allied health professionals to their funder and were meeting with their local disability manager in an attempt to source essential services such as speech and language therapy and psychology input for a number of residents.

A number of improvements had occurred as a result of actions taken as apart of the providers national improvement plan. These included improvements in recognising, reporting and documentation relating to safeguarding. They also included improvements relating to the polices, procedures and practices relating to residents' finances and contracts of care. There had also been an increase in the number and frequency of staff and management meetings, the frequency of audits, and the standardisation of some documentation across the designated centre. The inspectors also acknowledge that areas of good practice and further improvements were noted since the last inspection in relation to residents' rights, complaints, protection against infection, and fire precautions.

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. As previously mentioned, staff spoke about improvements in relation to consistency of staff and the impact for residents in relation to the continuity of care and support for them, and on team working in the centre. However, the centre remained under-resourced and the inspectors also found that some resources were not being used effectively.

While there had been an increase in the number of audits completed in the centre, from the sample reviewed these audits were not found to be picking up on areas of improvement in line with the findings of this inspection. For example, the inspectors viewed an number of assessments and incidents which had not resulted in the development of care plans or risk assessments.

Management and house meetings had been occurring regularly and topics discussed were found to be resident focused. The house meetings were reviewing incidents and identifying changes in residents' care and support needs and identifying the actions required to support them. However, the actions identified at these meetings were not always being being completed as planned, and were not leading to the

review and updated of residents' personal plans.

The inspectors were informed by the person in charge who had commenced in the centre in February 2021, that they had resigned their post and was due to finish in the centre at the end of July 2021. The provider had recruited to fill this position with a new person was soon due to take up their position. They would be the fourth person identified by the provider as the person in charge since September 2020. The person participating in the management (PPIM) of this centre in February 2021 was on leave at the time of this inspection, but the other PPIM was supporting the local management team and completing supervision with the person in charge. This PPIM had a large remit within the organisation.

The provider had completed a six monthly unannounced visit in March 2021 and another was planned the week after the inspection. The provider was using a new template and self-identifying areas for improvement. They were incorporating actions from six monthly, annual review and compliance plan into an improvement plan to track the completion of actions. A large number of these actions were complete but some remained outstanding in areas such as auditing, the review and update of residents' plans, staff training, the maintenance of rosters and the notification of incidents to the Chief Inspector.

Some improvements were noted since the last inspection in relation to staff access to training and supervision and the number of staff on duty in some of the houses at key times. Although, as recently identified by the provider in the dependency needs assessment completed for all residents, staffing numbers remained unsuitable to meet residents' current care and support needs. Management communicated that recruitment for 4.6 whole time equivalent posts was in process, with interviews scheduled the week after the inspection. Staff shortages meant that at times the centre was reliant on relief and agency staff members to cover and fill shifts very regularly. In addition, the agency staff were referred to on some rosters only by their first name or agency name which did not allow for assurance regarding skill mix of staff or for identification of staff on duty.

There were complaints policies and procedures in place in the centre and residents and their representatives indicated they were aware of who to go to if they had any concerns. From the sample of complaints reviewed the provider was recording and following up on complaints in line with their polices and procedures.

Regulation 15: Staffing

While improvements were noted in relation to staffing numbers and continuity of care and support for resident through the use of regular relief and agency staff, further improvements were required to ensure there were sufficient numbers of staff employed in the centre to ensure consistency of care and support for residents.

This was further compounded by the fact that two residents had significant changes in their support needs since the last inspection. The provider had completed a

review of residents' dependency needs assessments and identified the need for more staff in order to meet residents support needs.There were 4.6 WTE vacancies at the time of the inspection, and interviews were planned the week after the inspection.

There had also been two resident complaints recorded since the last inspection in relation to high levels of staff turnover and unfamiliar staff, and the lack of availability of staff to support them for activities. As previously mentioned, residents representatives also highlighted these issues. On the rosters for one of the houses an average of 31% of shifts were covered by agency staff, and in another house there were agency staff on duty 17 out of 25 shifts.

As previously mentioned the provider was filling shifts by using agency staff. However, from the sample of rosters reviewed it was not always clear if all shifts were covered or who these agency staff were. For example 9 shifts on one roster did not have any name beside the required shifts, the agency staff's hours were not recorded, and some rosters only contained the first name of the staff member.

Inspectors reviewed staff personnel files and found improvements since the previous inspection, those reviewed contained the information required in Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

Although improvements were also noted in relation to staff accessing training, there remained a number of staff who required some training/refresher training. A number of staff required training/refresher training in relation to fire safety, managing behaviour that is challenging, manual handling, safe administration of medication, and epilepsy rescue medication training. Inspectors acknowledge that staff were booked onto some of these training courses.

In line with an increase in allegations of abuse in the centre, the provider had sought out additional applied safeguarding training and the majority of staff had completed this, with seven staff booked on to complete it the week after the inspection.

Formal staff supervision was being completed with staff, and from the sample reviewed discussions appeared open and honest, and staff were afforded opportunities 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. Their roles and responsibilities, areas of strength and areas where they may need to further develop their skills were included in the records of these meetings.

Judgment: Substantially compliant

Regulation 23: Governance and management

While improvements were noted in relation to the availability of systems and templates, and while there was evidence of an increase in meetings and audits, the inspectors found that there remained gaps in relation to the monitoring and oversight of residents' care and support in the centre.

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 remained concerned that a sustainable governance and management team was not yet in place in this designated centre

The centre under-resourced in terms of staffing numbers, and the provider was not found to be making the best use of resources available to them. For example, there was a full time person in charge and a quality and safety lead who were not counted as part of the staffing quota. In addition, there were two house co-ordinators and a team leader who were not counted as part of the staffing quota at least 50% of their time.

While the provider was identifying areas some of the areas for improvement in line with the findings of this inspection, as part of their reply to the provider assurance report issued by the Chief Inspector in May 2021, they had not identified areas for improvement in relation to the areas found not complaint with the regulations on this inspection such as, governance and management, positive behavior support and safeguarding and protection.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents were protected by the admissions polices, procedures and practices in the centres. Further improvements had been made since the last inspection in relation to residents' contracts of care. They detailed the support, care and welfare of the residents, details of the services provided and the fees to be charged.

Most residents had an updated contract of care in place which they had signed. Contracts of care were made available in a format to suit each residents' communication preference and they had been supported to understand the amendments made to their contract of care. By choice, two residents had not signed their contract as they were seeking additional information from the provider in relation to fees relating to holidays and transport.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspectors found that the provider had not ensured that some notifications were submitted to the Chief Inspector of Social Services within the required timeframes.

Six notifications relating to allegations of abuse had not been submitted within three days as required by the regulations.

During a review by the provider they had identified a number of non-serious injuries which had not been notified in 2020. These were submitted retrospectively since the last inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were complaints policies and procedures in place, and residents and their representatives indicated they were aware of who to go to if they had any concerns. From the sample of complaints reviewed the provider was recording and following up on complaints in line with their polices and procedures.

The provider had plans to complete some further training with staff to ensure that they were recognising, recording and appropriately following up on informal complaints.

Judgment: Compliant

Quality and safety

The provider was striving to improve the quality and safety of the service for residents living in the centre. From what inspectors observed residents lived in warm, clean and comfortable homes where every effort was made to make them homely and to ensure residents personalised their spaces. The provider was aware that a number of houses required some maintenance and painting and decorating completed. Inspectors noted that the residents appeared well cared for and were actively engaged in activities over the course of the day. They provider had brought about a number of improvements but they needed to make further improvements in relation to safeguarding residents, ensuring residents had access to and support

from allied health professionals, and to ensure that documentation was in place to guide staff practice to support residents' care and support needs in a consistent manner.

Residents' support plans were not being updated or used to inform the delivery of care and support. At the opening meeting the provider identified that two resident had significant changes in their care and support needs since the last inspection and when inspectors reviewed their comprehensive assessments of need, they had not been updated to reflect these changes. Some residents' assessments were last completed in 2018. They did not reflect the changes in their support needs and these residents did not have care plans to guide staff in relation to a number of their support needs. In addition some documents guiding staff contained conflicting information e.g. Speech and language therapy plans, care plans and the procedure for thickening fluids differed. Inspectors did find that staff were familiar with residents' current care and support needs in the centre. However, as there was a heavy reliance on agency staff, this may present as a risk for residents.

While improvements had occurred in relation to the reporting, recording and documentation relating to safeguarding in the centre the provider the control measures and actions relating to one open safeguarding plan in the centre were not proving effective and required review and further action to bring about improvements in relation to residents' lived experience in the centre.

As previously mentioned, the premises in the centre were clean and homely and residents bedrooms were personalised to suit their tastes. The provider highlighted to inspectors that a number of maintenance and some upgrade works were required in the centre during the inspection relating to bathroom facilities, the replacement of a number of kitchen cabinets and counters, the replacement of a number of pieces of furniture, and some painting and decoration, the review of the gradient of a ramp into one of the premises, shelving to be replaced, and moss to be removed from roof's. The provider now had a new regional maintenance coordinator and all the required maintenance and repairs had been escalated and were on a list for completion.

There were cleaning schedules in place to ensure that each area of the centre was regularly cleaned, including regular touch point cleaning. The provider had developed or updated existing policies, procedures and guidelines to guide staff in relation to infection prevention and control during the pandemic. There were adequate supplies of personal protective equipment (PPE), and systems in place for stock control. Staff had completed a number of infection prevention and control related trainings since the start of the pandemic.

There were effective fire management systems in place. Suitable fire equipment was available and regularly serviced. There were adequate means of escape which were kept unobstructed and emergency lighting was in place as required. Residents had detailed personal emergency evacuation plans in place. Fire drills were occurring regularly and demonstrating that residents could safely evacuate the centre in a timely manner in the event of an emergency.

The provider was aware that they were not meeting the positive behaviour support needs of a number of residents. Some plans had been developed by staff in the centre, and for some reviewed there no evidence of the involvement of allied health professionals in their development or review. The inspectors were provided with evidence that the provider had sought additional support from the relevant health and social care professionals for some residents.

Regulation 12: Personal possessions

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

Residents had financial assessments in place and were being supported to manage their finances. Records of residents' income and expenditure were maintained and were being regularly audited.

Residents had access to space to store their personal belongings and to store and maintain their clothes and possessions. The had access to laundry facilities should they wish to use them.

Judgment: Compliant

Regulation 17: Premises

The premises was designed and laid out to meet the number and needs of residents in the centre. The houses were clean and comfortable and residents had access to private and communal spaces and could met friends and family in private if the so wish. They also had access to suitable storage facilities for their personal use.

As previously mentioned the provider had identified the need to complete a number of works and repairs in the centre and these had been escalated to the provider and were on a list for completion.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Residents were protected through the infection prevention and control policies, procedures and practices in the centre. Staff had completed a number of additional

trainings in relation to infection prevention and control and the provider had developed contingency plans for use during the pandemic.

The premises was found to be clean throughout and there were cleaning schedules in place to ensure that each area of the centre was being regularly cleaned.

There were suitable systems in place for laundry and waste management and there were also systems in place to ensure there were sufficient supplies of PPE available in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements for detecting, containing and extinguishing fires in the centre. There were adequate means of escape and emergency lighting in place. Plans were in place to provider more emergency lighting in one of the premises in line with an external consultant's recommendations, and the provider was in the process of reviewing the fire door ratings in this house also.

There were systems to ensure fire equipment was regularly serviced, tested and maintained. The evacuation plans were on display and residents' personal emergency evacuation plans were detailed in relation to the supports they may require to safely evacuate the centre, both during the day and at night.

Fire drills were occurring regularly by day and night, to demonstrate that residents could safely evacuate the centre in a timely manner. One resident talked about difficulties they had during recent fire drills in the centre. Alternative arrangements were now in place and it was documented that they had recently taken place in a successful night time fire drill.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was an absence of an up-to-date comprehensive assessments of need for residents and guidance for staff in relation to some residents' care and support needs. There was also conflicting information found in a number of residents' personal plans. Staff on duty were found to be aware of residents' care and support needs but the provider had identified in the latest six monthly provider visit that this was not always evident. In addition, due to the staffing vacancies in the centre there was a heavy reliance on agency staff.

Team meetings in the centre were found to be recording some changes relating to

residents' care needs; however, this information was not being updated into residents assessments or personal plans.

Judgment: Not compliant

Regulation 6: Health care

It was evident that efforts were being made by the provider to support residents to access allied health professionals. These included access to psychology service, speech and language therapy and dieticians. The provider had escalated their concerns to the funder and had a meeting planned with them after the inspection.

As previously mentioned there was an absence of an up-to-date assessment of need for some residents in line with their changing needs. From a sample of residents' plans reviewed there were identified healthcare needs which did not have corresponding care plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors found that there was limited oversight of positive behaviour support in the centre. There was an absence of clear guidance in place for staff in relation to supporting residents. There were a number of documents in place, but these had not all been developed or reviewed by the relevant professionals.

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.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to protect residents from all forms of abuse. Not all residents in this centre were found to be safe and protected on the day of inspection. While some residents spoken with, told the inspectors they felt safe and well supported in their homes, others reported feeling anxious and concerned.

While there had been improvements, the safeguarding arrangements in place in one of the houses were not effective in protecting residents from the risk of abuse. 40

notifications relating to safeguarding concerns had been submitted since the last inspection with the majority of these relating to alleged verbal and psychological abuse.

While the provider had revised their safeguarding policy and had taken action to better identify safeguarding issues and to record and report them, as previously mentioned the actions taken and control measures in place in some safeguarding plans were not providing effective and required review and further action by the provider to ensure residents were happy and felt safe in their home.

Judgment: Not compliant

Regulation 9: Residents' rights

There was information available and on display in relation to advocacy services and a number of residents were being supported to access independent advocacy services. Residents were seeking the support of an advocate in relation to a variety of issues such as safeguarding, housing, and changes in their care and support needs.

Residents were also attending advocacy groups within the organisation and for one resident, one of the benefits of attending this group was that they then felt comfortable and had the confidence to raise their concerns about their contract of care to the provider.

Resident meetings were occurring regularly and residents were involved in decisions about the day-to-day running of the centre. They were being encouraged to make choices and where at all possible to maintain their independence.

Throughout the inspection staff were observed treating residents with dignity and respect and to take the time to listen to and respond to them appropriately.

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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Bridge Community OSV-0003605

Inspection ID: MON-0032928

Date of inspection: 15/07/2021

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: • Staffing allocations against assessed needs has been completed nationally and recruitment is underway to recruit to the allocated numbers of WTE with new posts and a corresponding reduction on agency within the community. • All vacancies are in progress through the recruitment process. • A review of staffing and skill mix was conducted by the new Person in Charge in conjunction with the Quality and Safety Co Ordinator and House Co- Ordinator's on the 12th of August. Staffing and skill mix will be allocated in line with the assessed needs of the CMSN's and to ensure a balance of agency to core staff is in place during the recruitment process. • Details of all staff including full names, surnames, roles are outlined on the roster, using color coding to ensure identification of each staff member, their specific roles and scheduled hours rostered. • Rosters also include House Co Ordinator names and roles, Quality and Safety Coordinator and the Person in Charge name and hours.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

• A Training Needs analysis has been completed by the new PIC, Quality & Safety Coordinator in conjunction with the National learning and Development Officer and a monthly review of training needs will be carried out. Completed on 13.08.21.

• Staff not meeting training requirements on the day of the inspection have now completed the specific training required. This was completed by 16.08.2021

• All new employees are subject to a robust training induction plan which includes all mandatory training, and an induction into the house each new employee member will be working.

• To ensure all staff receive Supervision in line with organisational Policy, a schedule is in place and being reviewed by Person in Charge and Quality & Safety Coordinator on a monthly basis.

• The Person in Charge and Quality & Safety Co Ordinator to audit the training and supervision of staff monthly to ensure all training is up to date and valid, this is a standard agenda item on monthly meetings in the centre.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• A new PIC commenced working in the service on the 04.08.21. This individual has the relevant management qualification and experience required to fulfil the role. In addition, this individual also possesses a qualification to master's degree level in Applied Behaviour Analysis.

• There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organisation. The organisation is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service.

• Following each Internal and External announced and unannounced inspections, Annual Reviews and Health & Safety Audits the Person in Charge will ensure that all follow up actions identified are completed in a timely manner and integrated into the Centre's Community Improvement Plan which is maintained on a shared database with oversight from a local, regional, and national level.

• The Person in Charge and the Regional Manager will review the progress of the centre against the Centre's Community Improvement Plan on a weekly basis.

• The Regional manager will complete monthly supervision with the Person in Charge.

• The annual supervision schedule is in place for all staff and being reviewed by Person in Charge and Quality & Safety Coordinator on a monthly basis

• The Person in Charge and Quality & Safety Coordinator will conduct weekly, monthly, quarterly, six monthly and annual audits regularly for oversight on each house and oversight on residents and house files.

• The Person in Charge and Quality & Safety Coordinator are in the process of developing an annual audit schedule which will be in place and operational 30.08.21.

• Weekly meetings are held in each house and are uploaded to the community shared database (Sharepoint) which has oversight form a local, regional, and national level. All action will be escalated to the Person in Charge and Quality & safety Coordinator immediately where required.

• Weekly key worker meetings are held with each resident to discuss each resident's views on their care and plan actions in line with their will and preference. Records of these meetings are uploaded to the community shared database (Sharepoint) which has oversight form a local, regional, and national level. All action will be escalated to the Person in Charge and Quality & safety Coordinator immediately where required

• Community Management take place fortnightly with Person in Charge, Quality & Safety Co Ordinator and House Co Ordinators to review all aspects care provision to the residents. These meetings have an agenda that includes review of individual resident needs, safeguarding concerns, accidents/incidents, complaints, health and safety concerns, staff training needs and maintenance.

• Monthly Community team meetings with regional manager, clinical team, and regional safeguarding team. These meetings have an agenda that includes review of individual resident needs, safeguarding concerns, accidents/incidents, complaints, health and safety concerns, staff training needs and maintenance.

• Documents are uploaded to SharePoint where the Person in Charge and Quality & Safety Coordinator ensures daily oversight on all records of work completed in each house including residents' daily notes, incidents and accidents and financial transactions pertaining to each resident. The Bridge SharePoint Site is accessible to and is overseen by the local Management team, Regional Manager and relevant national teams.

• In addition to incident and accidents responded to, reported, and reviewed locally, all reports are circulated directly to the Person in Charge, CEO, Head of Services, Regional Manager and Health & Safety Lead for immediate action and review.

• There is an on-call system in place to provide support to the community when the Person in Charge is off duty.
• Supervision schedule is in place and being reviewed by Person in Charge and Quality & Safety Coordinator on 30.08.2021.

• PIC and Q & S Coordinator conduct weekly audits regularly for oversight, direct

oversight on community members, oversight on each centre and oversight on house files.

• PIC and Q&S are developing an annual audit schedule which will be in place and operational 30.08.21.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All Notifications will be submitted in line with regulatory requirements by both the Person in Charge and Quality & Safety Coordinator. Adherence to this will be monitored by the Regional Manager at monthly 1:1's and Community Management meetings.

• All incidents are discussed by the management team in consultation with the regional manager and the regional safeguarding Lead.

• Preliminary Screening Report is completed by the Quality & Safety Coordinator who is the Designated Officer for the Community in conjunction with the Person in Charge and the Regional Safeguarding Lead. The regional safeguarding lead has oversight on all Preliminary Screening Reports.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Weekly visual inspections occur in all houses where any repairs and maintenance issues are identified

• Repair works are prioritized and scheduled through an internal online process to log repairs on the system.

• The Person in Charge and Quality and Safety Coordinator have submitted a worklist for maintenance needs and upgrades for each of the four houses to the Regional Maintenance Coordinator on 15.07.21. Applications for capital funding will be made to the HSE where costs are beyond the resources available to the community.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• A comprehensive review of the needs of each CMSN is being carried out in partnership with input from relevant MDT professionals. All reviews and updates to be completed by 30.09.2021.

• The needs assessment will in turn inform each individual support plans and healthcare plans will be updated accordingly.

• A full and thorough review of all residents' support plans will be be completed by 31.10.2021 to ensure plans are aligned to the support needs of each CMSN.

• A review of each CMSN needs take place at the Community Management Meeting. Where a CMNS have changing needs the House Cordinator is responsible for the updating of all assessment and support plans. The Person in Charge will oversee that changing needs are being recorded and actioned through a review of service records at 1:1 Support and Supervision Monthly meetings with House Coordinators.

• Each CMSN is assigned a Keyworker who will meet with them monthly. At weekly team/House meeting they will update House Coordinators on any pertinent information relating to their assigned CMSN supports, plans, changes etc.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• A review of Healthcare needs of each CMSN will be carried out by the CCoI Clinical Team, PIC and Quality & Safety Coordinator from which health and allied healthcare appointments will be scheduled for each CMSN. Date for completion 30.9.2021

• An annual review of healthcare needs and a review of CMSN Healthcare needs is scheduled for August 2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Newly appointed PIC has Masters level qualification in Applied Behaviour Analysis and is working with CCOI clinical team to review the Behaviour Support plans for all CMSN at the Bridge Community. Date of completion 18/10/2021 • All BSP's will be reviewed by the Person in Charge and Clinical Support Officer and where required updated after each incident and required updates implemented. • Positive Behaviour Support Plans will be agenda item for update on communication at team meetings by the keyworker to ensure a consistent seamless communication re same. • The Person in Charge and Regional Manager will review Positive Behaviour Support Plans at weekly progress meetings.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • To address the identified concern, which was highlighted during the inspection, there is an ongoing compatibility issue a number of actions are to be progressed: o An external provider contracted to provide direct support to CMSN and enhance CCoI's ability to respond to unique requirements until permanent accommodation solution is determined. o They will provide: · Case Specific Review and Research about Highlighted Presentations · Assessment Interview(s) · Collateral history Assessment from Relevant Parties and Context Review · Completion of Psychological Behavioural Measures (if required) · Writing and report documentation · Key team Liaison · Ongoing work to include six sessions of support • Alternative accommodation within the designated centre has been identified as a potential option to meet the needs of one of these CMSN. This accommodation needs to be converted into a self-contained apartment, an application to register this space will need to be submitted and approved by HIQA. Estimated costings for these works were sent to HSE on 13/8/2021 and a full business case for capital will be submitted by the Head of Services by 31/8/2021	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	12/08/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	12/08/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Substantially Compliant	Yellow	12/08/2021

	circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	12/08/2021
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	16/08/2021
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.	Substantially Compliant	Yellow	15/07/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	15/07/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	30/08/2021

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	Red	30/08/2021
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	11/08/2021
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring	Not Compliant	Orange	31/10/2021

	in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Red	31/10/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Red	31/10/2021
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in	Not Compliant	Red	31/10/2021

	accordance with paragraph (1).			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/10/2021
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	31/10/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Not Compliant	Orange	31/10/2021

	frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/10/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/09/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Red	30/09/2021
Regulation 07(1)	The person in charge shall	Not Compliant	Red	30/09/2021

	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.			
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 cause of the resident's challenging behaviour.	Not Compliant	Red	30/09/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	31/10/2021