Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Camphill Community Dingle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	01 July 2019
Centre ID:	OSV-0003609
Fieldwork ID:	MON-0022538

About the designated centre

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

The centre comprised one detached house located in a rural location close to a large town. The service was available to adult male and females over the age of eighteen who have been diagnosed with an intellectual disability, sensory disabilities and/or autism. At the time of the inspection there were eight residents living at the centre. The staff members provide full time residential care and support to the residents. The centre is situated on a working farm and most of the food consumed is grown by the residents and staff. The residents engage in art and craft activities most of which is sold at local markets and fairs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
01 July 2019	09:00hrs to 18:00hrs	Cora McCarthy	Lead
01 July 2019	09:00hrs to 18:00hrs	Lucia Power	Support

What residents told us and what inspectors observed

Inspectors met with four of the residents during the course of the inspection. The staff members facilitated interactions between residents and the inspectors and it was clear from this that they knew the residents very well. The staff were very familiar with the residents communication methods and were able to translate the residents gestures and vocalisations.The staff provided individualised support and this was evident from observing their interactions. Staff were noted to support residents in a caring and dignified manner that was individual to their needs. Inspectors observed the residents in their home environment and they appeared to be happy and engaged well with staff.

Inspectors had tea with some of the residents and observed them being supported at tea break by a staff member. This support was given in an individualised manner and one resident was able to describe what activity they were doing next. Another resident told the inspector that the staff were very kind and that they felt very safe. Examples were given to the inspectors by a resident of how they their independent living skills were maintained and promoted by staff. The provider had held an annual local fair the previous day and the residents had baked all the foodstuffs for it and made other art and craft items for sale. One resident told the inspectors about their role in the house and how much they enjoyed the agricultural activities. Inspectors continued to note throughout the inspection the respectful manner in which the staff carried out their interactions with the residents.

Capacity and capability

There was a lack of effective governance, leadership and management arrangements in the centre that did not demonstrate a good quality and safe service was being delivered.

The provider was registered in December 2016 with a number of conditions. A restrictive condition was put in place that the action plan the provider submitted to the chief inspector on the 04 October 2016 would be implemented in full by 31 January 2017. One of the areas of this plan was to come into compliance with regulation 23 Governance and Management. The provider was to ensure that an annual review of the quality and safety of care and support would be completed. This was also an action arising from an inspection in January 2018. The provider did not have an annual report available to show the inspectors on the most recent inspection nor did they demonstrate that audits or reviews had taken place to ensure that the service is safe, appropriate to resident's needs, consistent and was effectively monitored. The provider was advised on the day of inspection that they

failed to comply with a condition of their registration.

The statement of purpose was last reviewed by the provider on the 3 July 2018 and not updated at intervals less than a year. The statement of purpose did not contain the information as set out in schedule 1.

The provider had written policies and procedures in place as set out in schedule 5, however the provider had not updated these policies in line with their own guidance.

The registered provider had in place staff to support the assessed needs of the residents, however there was a lack of consistent staff due to the use of agency. The provider at the time of inspection had 6.42 whole time equivalent vacancies and there was an over reliance on relief and agency which impacted on the continuity of care and support for the residents. The inspector reviewed documentation in respect of staff as set out in schedule 2, the provider has ensured all this information was on file and updated.

There was a training matrix in place with all mandatory and centre specific training outlined. The inspector noted that only one person had completed positive behaviour training and this was identified as a requirement for all staff given the assessed needs of the residents. It was also noted that four staff required training in the safe administration of medicines.There was evidence that staff received safeguarding and fire safety training.

The provider has in place a comprehensive supervision policy but this practice was not evident in the centre. There was a guidance document in place for supervision and this was not implemented as per the providers own guidance. There was a lack of understanding in relation to supervision and when the inspector asked staff if they were familiar with the policy they did not have awareness but did highlight they would benefit from appropriate supervision. There was no documentation available to the inspector to demonstrate that the provider was actively supervising the centre and staff told the inspector that there was a lack of structure in place as local issues did not always get attention nationally.

The registered provider had in place a complaints policy with identified training for staff as part of this policy. There was no evidence of training for staff and when the inspector spoke with some staff they had no awareness of the complaints procedure or process. There were individual complaints on file that were being followed up, but there was no record available of all complaints and details of any investigation, outcome or actions taken. There was no documentation available to demonstrate that the provider had oversight in relation to the complaints procedure.

The provider had not ensured that notifications in relation to adverse incidents in the centre were submitted to the chief inspector in a timely manner and were submitted retrospectively.

Regulation 15: Staffing

The registered provider had the number and skill mix of staff appropriate to the assessed needs. However there is an over reliance on agency staff which impacts on the continuity of care for residents. The provider had available all documentation in respect of staff as set out in schedule 2.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider has in place a training matrix, there were gaps in training in relation to mandatory training for relief staff. There was also a gap in training for staff in relation to positive behaviour training. The provider had not ensured that staff were appropriately supervised.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider maintained a directory of residents in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not have management systems in place to ensure that the service provided is safe. There was no annual review of the quality and safety of care and support in the designated centre. The provider did not have in place effective arrangements to support, develop and performance manage staff.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Registered Provider did not have a statement of purpose containing the information set out in schedule 1.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications of adverse incidents in the designated centre were not submitted within the identified time frame and were submitted to the chief inspector retrospectively.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had in place a complaints procedure. However there was no record of all complaints available on the day of inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The provider had in place policies and procedures as set out in schedule 1. However some of these policies required review as per the providers own time lines.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors observed that the quality of the service received by the resident was good. However the provider had failed to safeguard residents in terms of following guidance around safe use of the Internet.

The person in charge ensured that an assessment, of the health, personal and social care needs of each resident was carried out and plans put in place to support the residents' individual needs. However some support plans were out of date and required review and there was contradictory information within the personal plan.

Overall the health and well-being of the residents was promoted in the centre. Each resident had access to a general practitioner of their choice. Where treatment was

recommended by allied health professionals such treatment was facilitated.

The provider had ensured that residents had a communication profile completed and were supported to communicate in accordance with their needs. The staff were observed to be familiar with the residents individual communication requirements and their approach was noted to be very person centred. The provider had ensured that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and Internet.

The residents were supported to spend their day in a manner that was meaningful and purposeful for them. This included engaging in agricultural activities, community facilities and amenities. The residents had access to occupation and recreation facilities and opportunities to participate in activities in accordance with their interests, capacities and developmental needs. There were supports in place for residents to develop and maintain personal relationships in accordance with their wishes.

The residents had their own bedrooms, access to shared spaces and adequate room for family or friends to visit at each resident's request. Inspectors observed that the residents' home was warm and homely.

There provider had a risk management policy in place. The person in charge had identified appropriate risks and had completed risk assessments for them. However the control measures as outlined in the risk assessment had not been implemented thus posing a risk to the resident.

Where behaviours that challenge were identified a positive behaviour plan was put in place. However the recommendations from the behaviour support plan were not implemented. An example of this was where a recommendation was made for one resident to receive education around safe use of Internet and also a recommendation for visual supports to aid understanding and alleviate frustration around inability to communicate clearly.

Regulation 10: Communication

The provider had ensured that residents had a communication profile completed and were supported to communicate in accordance with their needs. The provider had ensured that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and Internet.

Judgment: Compliant

Regulation 13: General welfare and development

The provider ensured that each resident received appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and their wishes. The residents had access to facilities for occupation and recreation; opportunities to participate in activities in accordance with their interests, capacities and developmental needs and supports to develop and maintain personal relationships in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

The inspectors observed that overall the residents' home was warm and homely and maintained to a high standard.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place. The person in charge had identified appropriate risks and had completed risk assessments for them. However the control measures as outlined in the risk assessment had not been implemented thus posing a risk to the resident.

Judgment: Not compliant

Regulation 28: Fire precautions

Personal evacuation plans were in place for all residents and were effective.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that an assessment, of the health, personal and social care needs of each resident was carried out and plans put in place to support the residents' individual needs. However some support plans were out of date and required review and there was contradictory information within the personal plan.

Judgment: Substantially compliant

Regulation 6: Health care

Overall the health and well-being of the residents was promoted in the centre. Each resident had access to a general practitioner of their choice. Where treatment was recommended by allied health professionals such treatment was facilitated.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where behaviours that challenge were identified a positive behaviour plan was put in place. However the recommendations from the behaviour support plan were not implemented.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to protect residents from all forms of abuse as they did not adhere to guidance around safe use of the internet.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Dingle OSV-0003609

Inspection ID: MON-0022538

Date of inspection: 01/07/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: It is acknowledged that the current reliance on Agency staff has impacted on the consistency of care and support to residents. There have been two recent recruitment drives in June and July 2019. The National Operations & Finance Review process was introduced by the CEO in the latter part of 2018.The assessment of a review in each service is to establish the required Whole Time Equivalent (WTE) based on assessed need for service. This process was completed in Dingle in June 2019. A key task of the new PIC will be to recruit the agreed WTE for the Service. This will include full time, part time and relief staff and will replace the reliance on Agency staff. We plan to have all agency replaced by directly employed staff including a relief panel by 31/12/2019	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training Matrix is up to date with all staff included, plan for all mandatory training and will be monitored by the Service Quality & Safety Lead who will carry responsibility for Training. Safeguarding Training is now completed with all staff. Meds Training scheduled for 29th and 30th August Day 2 Studio 3 Positive Behaviour Training planned for 19/09/2019 An inhouse Information Day on HIQA regulations will be delivered to staff by 1/12/2019	

A selection of training from An Cuan will be offered to all staff on a phased basis. This includes:
Sexuality & Sexual Education within Intellectual Disability
Risk Assessment Workshop
Autism Spectrum Conditions
Communication Training
Positive Behaviour Supports
Person Centered Planning

Supervision Training is planned for House Coordinator, Deputy House Coordinator and Day Service Coordinator. The PIC will complete 4-6 weekly supervision with each of these key roles. A schedule of Supervision will be drafted for all staff 6 weekly and will be monitored and audited by the PIC. The PIC will provide support for Coordinators and ensure oversight of their supervisions to ensure they are of a professional quality. The PIC will audit compliance with this schedule quarterly and report as a service KPI. The Regional Manager will complete Support & Supervision to the PIC on a 6-8-week basis. A schedule of Supervision for all staff will be in place by 30/9/2019

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Annual Review will be planned and completed by the PIC and Regional Manager by 30/11/ 2019. This will consider the last two last HIQA inspections and the unannounced Inspection by Camphill. This plan will be reviewed and revised reflective of progress on implementation of inspections, new issues that arise, feedback from engagement with residents, families and other key stakeholders.

Staff supervision process will focus on individuals taking professional responsibility for the safety of the services they deliver. Overview of the quality of supervisions process will be established by the PIC ensuring qualitative review and feedback on the supervision process and its capture of responsiveness to care and support needs and personal goals of residents. Roles and responsibilities will be allocated to staff based on training, ability, skill level and interest. 30/10/2019

A schedule of training based on the identified needs within the Service will be delivered in conjunction with An Cuan Services. Training has commenced and will be completed by all current staff by 20/12/2019
Rostering to ensure on site management/ supervisory presence 7 days a week.
A daily reporting procedure has been introduced so that any care issues or incidents are communicated effectively, and notifications reported in a timely response. Actions will be reviewed at fortnightly Care & Welfare meetings. Minutes of both Management Team and

Welfare Group are circulated to Regional Manager (RM). Weekly Checklist from House Co-ordinator to PIC are generated and a summative weekly checklist from PIC is sent to RM Weekly. PIC will attend a Team meeting at least once a month. Minutes of all team meetings sent to PIC. 30/09/2019

Key worker system is being developed by Clinical Lead with a Comprehensive Needs Review for all Residents to be completed by 31/10/2019. Clinical Lead will also work directly with the PIC in reviewing and implementing Positive Behavioural Support Plans in conjunction with the National Behavioural Support Specialist. The Clinical Lead will also have oversight of existing or new restrictive practises.

Regional Safeguarding Lead monitors and offers support to all Safeguarding concerns and are monitored by National Principal Social Worker
Appraisal Schedule to be planned by December. Appraisals will be performed in line with Policy where a senior member of management and direct manager will annually review an employee's performance and create an action-based plan with the employee to improve their performance. 16/12/2019

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose will be updated to the HIQA Template with all relevant information up to date by PIC and Regional Manager by 30/9/2019

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The newly appointed PIC's induction & training will include PIC's responsibilities towards meeting regulatory reporting requirements. Focused supervision for all staff to ensure regulatory responsibilities are being followed.

The DO and Deputy DO both completed HSE Designated Officer training by 01/08/19 and are participants in CCOI's scheduled monthly CCoI Designated Officers training ensuring they are aware of their specific role in supporting the PIC complete notifications within 3 days

All personnel completed refresher training in safeguarding by 14/08/19 to ensure they are aware of their responsibility towards same day reporting to support the PIC complete notifications within 3 days

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The DO also carries responsibility for Complaints. A dedicated Complaints folder is in situ and the Complaints Tracker is up to date and there is National oversight of the complaints tracker by Regional Manager and Principle Social Worker. The PIC will monitor and manage complaints. Complaints Training will be delivered to staff by 31/10/2019. Complaints training will be delivered to all residents by 30/11/2019.
All complaints will be reviewed at the fortnightly Care & Welfare meetings and will also be discussed in Supervision.
All complaints are returned to the HSE on a quarterly basis.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A Policy Coordinator has been appointed nationally to review existing policies and develop new policies.
A plan will be developed to update all policies.
Priority will be given to update the 21 policies of Schedule 5 in Statutory Instruments SI No 367 of 2013. These will be completed by 31/01/2020.
All policies updated will be introduced locally to Dingle. The PIC will bring new policies to Team meetings and ensure there is a process to read, discuss, understand and sign having read the policy. 1/11/2019

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All General, Residential and Personal risk assessments to be reviewed by the management team to identify control measure and actions that are not in place. Risk with the highest residual risk rating will be prioritised by 30/09/2019.
Outstanding actions and control measures to be assigned to the relevant members of the management team to action. 30/09/2019
An action plan and tracker are to be put in place to ensure that all outstanding actions are implemented by 30/11/2019.
Progress on the implementation of outstanding actions to be reviewed fortnightly by National Risk Lead.
All staff will be trained in completing Risk Assessments, in identifying and implementing controls and other appropriate risk reduction responses such as Standard Operating Procedures. 30/11/2019

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Residents will be supported to appoint a team member of their choice as a key worker to meet with them and prepare for a comprehensive needs review. The outcome of each comprehensive needs review will inform, revise and update each residents Person Centered Plan including their Care and Support needs and their chosen quality of life goals for the coming year. This action has been taken to ensure that each Residents support needs will be fully reviewed, and all PCP will be revised to accurately reflect each resident current support needs across both health care and support needs and quality of life goals. Action to be Completed by 31/10/19

For all residents who have a positive behavioural support plan a multidisciplinary review of this plan will be informed by input from the Regional Behavioural Specialist, Studio 3 Psychologist (where available), PIC, House Co-Ordinator, SLT / communications specialist if applicable. Information gathering to inform this work will include analysis of ABC charts, Behaviour trackers, GP feedback, SLT care plans, Psychiatry notes, Psychology recommendations, TUSLA if applicable, Incident/Accident Audits, Risk Assessments, Family Feedback and Residents Choice. Aim of this action is to ensure the comprehensive needs assessment for Residents with complex behaviors is informed by a multi-disciplinary team approach and is comprehensive and all positive behavioural support plans are up to date and reflective of current presentations and describe appropriate strategies for staff to respond with when supporting the person. Action to be Completed by 31/10/19
Audit of PCP's will be a key item in the Audit Schedule for the PIC.
Audit Schedule to be revised to reflect the above action by 30/9/2019

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Staff training in Positive Behavioural Supports. Staff training in the Positive Behavioural Supports is planned for last week in September. Training will be directed to ensure staff have a clear understanding of function of PBS and how it relates to the planned supports and programs for Residents who have PBS in place. The first day of this training program was delivered on 14th of June 2019 and the 2nd day for staff who have not received the training is planned for Thursday 12th of September 2019. This action will be taken to ensure that staff have the skills and knowledge to consistently implement the planned positive behavioural supports as described in the PCP of Residents who are currently presenting with complex behaviours. Action to be completed by 31/09/19

A full review of all residents Positive Behavioral Support Plans will be undertaken by PIC with the support of the National Behavioral Support Specialist and National Clinical Lead. This review will be informed by individual residents' comprehensive needs review processes, feedback from the staff team and a review of incidents reports for each resident from the past year. This action will be undertaken to ensure all Positive Behavioral Support Plans are accurate and up to date and respond to the currents presenting expressions of complex behavior. Action to be completed by 31/09/19

PIC and staff management will facilitate all staff to review their implementation of the current positive behavioral support plans as an agenda item at a fortnightly Care & Welfare meeting. All reports of behaviors of concern within the preceding fortnight will also be reviewed as an agenda item at this meeting. The aim of these agenda items will be to facilitate staff to focus on and learn from occasions of good practice and, where outcomes have not been satisfactory, to identify the factors which might have influenced this. Reflective discussions of strengths and weakness in the implementation of positive behavioral support will enable the team to learn from their experiences and support a clear consistent implementation of the strategies described for each person who has a positive behavioral support plan. This approach will create a space for the PIC and management team to use the agenda of the care and welfare meetings to supervise and support staff to implement the training in positive behavioural support staff have received. The action aims to ensure staff are consistent in the implementation of positive behavioral support plans and to ensure where new behaviors emerge staff recognize these quickly and respond consistently. Action to be completed fortnightly as part of the care and welfare meetings.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A Safeguarding Service Improvement Plan as has been agreed by the HSE on 22/06/19 will be implemented on a sequentially phased basis, of which CCoI Dingle will be part of. The implementation of this plan will be managed by CCoI National Governance Office and overseen by a HSE oversight group from CHO area 5.

All personnel completed refresher training in safeguarding by 14/08/19 which included emphasis on their responsibility towards preventing, protecting and promoting a culture of zero tolerance of all forms of abuse.

All residents to have received safeguarding training by 26/08/19. This will be delivered annually, or more often as identified as required.

A Risk assessment will be completed for each of the four residents who access the internet – to be completed by 31/08/19

A training programme on internet safety for all residents who have access to the internet will be scheduled and delivered. This has commenced with a 1:1 internet safety education workshop on 12/08/19 and staff training scheduled for 22/08/19 by an external specialist trainer
External consultancy now in place from An Cuan specialist support services for all staff who will be delivering 1:1 internet safety education programmes.

The PIC and Regional Manager will have a regular presence in Dingle with an emphasis on observing practice and providing assurance to the SMT and the Board of CCOI that the actions and interventions outlined in this assurance plan are delivering safe and acceptable practices of care and support to residents. Observations will be supplemented by feedback from residents and their families / advocates on quality of care and support. Incidents, safeguarding, accident and risk registers will be monitored and reviewed by PIC with oversight by Regional Manager, Principle Social Worker and Clinical Lead.

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(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.	Not Compliant	Yellow	31/12/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	20/12/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2019
Regulation 23(1)(a)	The registered provider shall ensure that the	Not Compliant	Orange	30/11/2019

	designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/10/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with	Not Compliant	Orange	30/11/2019

	standards.			
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	26/11/2019
Regulation 23(1)(f)	The registered provider shall ensure that that a copy of the review referred to in subparagraph (d) is made available to residents and, if requested, to the chief inspector.	Not Compliant	Orange	30/11/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/11/2019
Regulation 23(2)(b)	The registered provider, or a person nominated	Not Compliant	Orange	30/11/2019

	by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	20/12/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the	Not Compliant	Orange	02/12/2019

	following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	02/12/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	30/09/2019
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Yellow	30/09/2019
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,	Not Compliant	Orange	01/11/2019

	suspected or confirmed, of abuse of any resident.			
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.	Substantially Compliant	Yellow	30/11/2019
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	30/10/2019
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Yellow	30/11/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a	Not Compliant	Yellow	01/11/2019

	complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/01/2020
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.	Substantially Compliant	Yellow	31/10/2019
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	Substantially Compliant	Yellow	31/10/2019

	is a change in needs or circumstances, which review shall be multidisciplinary.			
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	Orange	30/09/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2019
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.	Not Compliant	Orange	30/09/2019