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:	Camphill Community Grangemockler
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	31 July 2020
Centre ID:	OSV-0003622
Fieldwork ID:	MON-0029615

About the designated centre

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

Camphill Community Grangemockler consists of five large separate houses all within short walking distance to each other. These houses are located in a rural area on the site of a farm and are in close proximity to a small village and some towns. Each resident had their own bedroom and facilities within the centre include sitting rooms, kitchens, dining rooms, utility rooms and staff offices. The centre provides a residential service for up to twenty-one adults, male and female, with intellectual disabilities, Autism and those with physical and sensory disabilities. In line with the provider's the model of care, residents are supported by a workforce consisting of paid staff and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Friday 31 July 2020	09:00hrs to 17:00hrs	Tanya Brady	Lead
Friday 31 July 2020	09:00hrs to 17:00hrs	Sinead Whitely	Support

What residents told us and what inspectors observed

This centre is home to 17 residents although on the day of inspection two residents were at home. Inspectors had the opportunity to meet with eight residents. This inspection took place in the middle of the COVID-19 pandemic and communication with residents, staff and management took place from at least a two metre distance and was time limited in adherence with national guidance.

Inspectors spent a period of time reviewing documents in an office area, centrally located on site and residents were observed over the course of the day engaged in activities both with staff and independently. The centre encompasses a small farm and residents were noted to help in working with the animals and enjoying the surrounding country. One resident was reminded by staff to put on their high visibility jacket for safety as they moved around. Others were seen to enjoy taking walks and visiting peers in their homes.

In one house a resident who enjoys art, had an area set up for them to paint in the living room. They were supported by a staff member and when the inspector was in the house the resident moved to relax in an armchair and requested a drink. Another resident was having a cup of tea at the kitchen table chatting to staff who were engaged in household tasks. A resident showed the inspector their room and their collection of posters and memorabilia from a favourite film. They asked that the inspector stand far away because of the virus. They explained they had learned all about COVID-19 and explained to the inspector that they could not shake hands. A resident who had been sitting outside with their cup of tea returned to the house as they wanted to make bread and staff commented that this resident was a talented baker. They also showed the inspector the notice board for the house which was in the hall and explained that they liked how the pins were arranged in a pattern which made it nice to look at. The staff were at all times engaged with residents and there was a comfortable and friendly atmosphere in the house.

One resident was observed completing one to one activities with staff in a separate quiet space. This was in line with the residents assessed needs and care plan. The resident had lots of personalised pictures and crafts displayed in their quiet space and appeared happy and comfortable there.

Capacity and capability

In June 2019, the Chief Inspector of Social Services received information of concern submitted through statutory notifications by the provider relating to a number of incidents of alleged financial abuse of residents. On the basis of that information, the provider was requested to provide assurances to the Chief Inspector following

these concerning findings. A serious safeguarding review of the management of residents finances in this centre had recently been completed by the provider at the time of this inspection. This matter related to the reported retrospective misappropriation of a large sum of resident monies. This inspection was risk based and was scheduled to review the provider's governance and management arrangements to ensure good quality care and support was provided to residents.

Prior to this inspection, Camphill Communities of Ireland had been required to submit a number of formal assurances to the Chief Inspector regarding the safeguarding arrangements for residents and the safety and quality of care delivered across a number of their designated centres.

Overall inspectors found levels of compliance with the regulations remained on a par with the last inspection, with some systems for auditing and monitoring in place to provide a good quality and safe service to residents. There was evidence however that some financial audits had recently been revised as they had not consistently picked up areas of concern such as errors in spending for residents or in overcharging for residents contributions over a period of time.

Of significance in this centre, inspectors reviewed all matters pertaining to safeguarding notifications made to the Chief Inspector. A provider serious incident management review had determined large sums of resident monies had been misappropriated in this centre over a period of years. While the detail regarding this matter was reviewed on inspection (including the planned reimbursement of monies to residents) this matter was not concluded by the provider at the time of inspection and all residents had therefore not yet been reimbursed.

Staff and management were found to be welcoming and available to the inspectors throughout the inspection day, inspectors found no difficulties with accessing and reviewing all requested documentation. A full time person in charge was in place who had the experience and skills necessary to manage the designated centre. The person in charge was noted to proactively review systems when following incidents and was engaged in ensuring that the staff knowledge of processes was consistently updated. The person in charge was supported in their role by a quality and safety lead and by house co-ordinators in each of the houses that comprise this centre. The person in charge, quality and safety lead and the house co-ordinators were a regular presence in the houses and all were involved in oversight of the daily running of the centre. Staff who spoke with the inspectors and were aware of who they could speak with if they had concerns and were familiar with the lines of accountability in the centre. However, oversight and monitoring of the centre at a provider level required improvements at times. An annual review of the care and support was completed for the centre for 2019 with actions identified. Some of these actions remained without a confirmed timeline, such as a review of staffing resources, in particular the use of short term co-workers. The provider had commissioned an external report to review these resources in February 2019 and this remained an ongoing action on the annual review.

A six monthly unannounced provider audit of the safety and quality of care and

support provided in the centre as required by regulation had taken place last in November 2019 and there had been one six months previously in April 2019. However, one due in May 2020 had not been completed. In early July 2020 the provider had organised for an external inspection to be completed for the designated centre. The purpose of this was to identify areas for improvement, the inspectors reviewed a draft of this and acknowledge that an action plan had not yet been compiled however it highlighted areas for improvement including finance management and infection control.

There was a consistent group of core staff employed in the centre. Staff who met with the inspectors were knowledgeable regarding the needs of the residents they worked with.Staff were seen to engage in an appropriate and caring manner with residents in their homes. The inspectors discussed concerns on the day with the person in charge and the management of the centre regarding the number of hours worked by short term co-workers (volunteers) in the centre. On reviewing the rotas the inspectors noted that the volunteer short term co workers were working more hours than the employed staff in the same house to ensure support for residents.

Inspectors observed a sample of staff personnel files and supervision records. In general, all Schedule 2 documents were in place as required. These included Garda vetting, employment history and employment references. However, one staff member was observed as not having up-to-date identification in place. Staff were completing one to one supervisions with their line managers four times a year and this included an annual appraisal. The person in charge had a clear schedule in place for supervisions that would soon be due. Staffing relief systems had been reviewed to ensure that a contingency plan was in place in the event that a number of staff should become unwell due to COVID-19.

All staff had completed mandatory training before commencing work in the designated centre. Staff completed training in areas including safeguarding, medication management, infection control, manual handling, children first and first aid. Additional training had been completed by staff in hand washing and donning and doffing of personal protective equipment in light of the COVID-19 pandemic. Some refresher training in behaviour management was overdue on the day of inspection. This had been postponed to a later date due to infection control restrictions in place. The centre had a designated training officer in place who regularly reviewed staff training needs and scheduled training days accordingly. Some staff members were qualified as an in house trainer in manual handling and fire safety.

The inspectors reviewed contracts of care for residents' and noted that they contained general information required by the regulations with a percentage contribution recorded. Additional charges that the residents were responsible for in relation to their day to day support were outlined on a schedule of charges. However, the centre had devised a centre specific document called 'disability allowance contribution agreement' which was designed to give the specific amount of contribution not identified on the contract. Inspectors found some ambiguity with the practical application of such localised procedures. For example, inspectors noted on one that a resident had not signed although their name had been added

and an amount had been amended and increased with no evidence that consent/consultation had been gained and no date or signature was beside the change. This was discussed with the person in charge who made immediate contact with the resident. The provider had highlighted to inspectors that they planned to introduce a new contract for all residents (nationally across their service) which had been a feature of a number of recent inspections.

The registered provider is required to have specific written policies in place and these are to be reviewed at intervals no longer than three years. Policies reviewed by the inspectors on the day had not been reviewed as required by the registered provider within the required time frame. This was particularly relevant as the provider had set time lines for the review and amendment of key policies and procedures and notified the Chief Inspector of Social Services of same. These had not been met and staff were therefore operating in the absence of provider led and approved polices. For example, the providers safeguarding policy was last reviewed in 2016.

Regulation 14: Persons in charge

There was an experienced person in charge in the centre who had the experience and skills necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There was a core group of staff present in this centre, however the volunteer short term co-workers were providing levels of support over that of employed staff.

In general, staff personnel files had all Schedule 2 documents in place, however one staff member did not have up-to-date identification in place as required.

Judgment: Substantially compliant

Regulation 16: Training and staff development

All staff had completed mandatory training before commencing work in the designated centre. Staff completed training in areas including safeguarding, medication management, infection control, manual handling, childrens first and first aid

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure was in place which was known to residents, staff and co-workers in the centre. Audits were carried out in key areas to inform practice, however a number of auditing systems had been recently revised as they had not consistently identified areas of concern.

Annual reviews had been carried out as required by regulation. Six monthly unannounced visits had been conducted at the required intervals in 2019 but had yet to be carried out in 2020.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Contracts for the provision of services to residents were reviewed however the accompanying documentation setting out the fees to be charged was not signed or reviewed as required. There was no evidence that consent had been obtained in all instances.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Policies were in place as required under Schedule 5, however they had not all been reviewed as required by regulation. There was evidence that they were not all consistently guiding staff practice.

Judgment: Not compliant

Quality and safety

The inspectors reviewed the quality and safety of the service being provided to the residents and found good practice in a number of areas. Residents were facilitated in a person centred manner throughout the day as observed by

inspectors. However, some improvements were required by the provider in areas such as supporting residents in the management of their personal possessions and in risk management. In addition, this inspection afforded review of the infection control measures in place, in light of the COVID-19 pandemic.

Residents were observed throughout the inspection to be engaged in meaningful activities of their choice and where possible supported to develop their independence skills. For example residents were supported in their home with everyday activities such as cooking, putting away washing and gardening. In addition residents spoke of their favourite films and hobbies, and were seen going for walks and helping with jobs on the centre farm.

Inspectors reviewed care plans and practice in place for residents with some healthcare needs and found that residents were appropriately supported to manage these needs. Relevant referrals were being made to multi-disciplinary healthcare professionals and recommendations made by allied healthcare professionals were being implemented by staff. Pain management assessment tools were being used regularly and clear guidance was in place for the administration of pain medication used as required (PRN). Staff spoken with were familiar and knowledgeable regarding the residents individual needs and preferences.

All staff had received training in the safeguarding and protection of vulnerable adults. The provider and person in charge in addition to managing current cases whereby the safeguarding of residents was reported as a concern were also managing a number of historic allegations that had not been either closed or resolved in accordance with the providers timelines. In total over the 12 months of 2019 there were 170 safeguarding cases recorded of which approximately half were current cases, the rest were historic allegations, with a small number from 2018 also still open. These varied from alleged cases of physical, psychological, and financial abuse occurring in this centre. The provider was reportedly also liaising with the Health Service Executive (HSE) regarding other retrospective safeguarding concerns that had been identified via a review of historic documents. Notwithstanding the very concerning high numbers of safeguarding cases in this centre, inspectors found a much improved system for the reporting and recording of safeguarding concerns (than had been evident on the previous inspection). However further improvements were required in this area to fully protect all residents from all forms of physical and financial abuse and fully address issues from historic safeguarding concerns. It was acknowledged by inspectors that the person in charge was attempting to change the safeguarding culture within the centre.

Some residents did not have full access to their own money at all times and some had no bank card or any sight of their accounts. In some instances, staff and management supporting the residents did not have oversight of the residents spending/finances. For example, whereby some families reportedly supported residents with their finances the resident/provider had no copies of bank statements/finances, and therefore could not complete audits in line with the providers own service policy.

Inspectors noted that the provider had concluded the process of reviews into areas

of significant financial safeguarding concern. A system had been put in place to begin the process of redress for individual residents that was transparent and clear albeit not yet concluded. However, during the process of review by the provider a number of subsidiary findings that had not been part of the original financial concerns were identified. Further action was required to ensure full redress is in place for these residents. For example, where residents had been paying for their own staff support, the provider had not ensured staffing levels provided were in line with their assessed needs.

Staff spoken with were knowledgeable regarding current processes in place for the management of residents finances. Systems were in place for the recording of daily expenditure and these were signed and dated by a minimum of two senior staff members. Residents personal finances were stored in secure facilities, and following a check on a sample of residents finances, inspectors found that records accurately reflected sums of money in place for individuals. These processes had required recent review following an incident where one residents bank card was used in error for an online purchase for another resident. Additionally, a centre specific document had been developed for the management of online transactions as the providers policy did not give guidance for this process. However centre specific processes that were in place meant overseeing and auditing like for like practice across designated centres from a provider perspective was a challenge.

There were risk management arrangements in place which included environmental and individual risk assessments for residents. Most outlined appropriate measures in place to control and manage the risks identified. Where residents presented with vulnerabilities and potential high risks secondary to lack of oversight of financial management systems this risk was not consistently identified, assessed, or mitigated. Specifically, where families supported residents with their finances, the provider had no oversight of this.

Inspectors found the centre to be visibly clean. Additional measures had been implemented for infection prevention and control due to the COVID-19 pandemic. Regular temperature checks were being completed by staff. Staffing teams had been reviewed and adjusted to reduce contacts in the houses. The centre had ample supplies of personal protective equipment (PPE) and hand washing facilities and alcohol gels were available throughout the centre for staff and residents to use. However, at times, the inspectors found the use of face masks was not adhering to national guidance. Some staff were not wearing face masks when providing care and support with residents within two metre parameters.

Regulation 12: Personal possessions

For some residents, family members were supporting them to manage their finances. At times, this posed difficulties and potential risks. Staff and management supporting the residents did not have oversight of the residents spending, at times they had no copies of bank statements, and therefore could not complete audits in

line with the service policy.

Judgment: Not compliant

Regulation 13: General welfare and development

Residents were seen to be supported to participate in activities of their choosing and were supported by staff in a person centred manner.

Judgment: Compliant

Regulation 18: Food and nutrition

Storage, monitoring and cleaning systems in place ensured that food items were stored in clean and hygienic facilities. Fresh and wholesome food was provided for residents daily. Residents were supported te be involved in food preparation and mealtimes.

Judgment: Compliant

Regulation 26: Risk management procedures

There were risk management arrangements in place which included environmental and individual risk assessments for residents. Where residents presented with vulnerabilities and potential high risks secondary to lack of oversight of financial management systems this risk was not consistently identified, assessed, or mitigated.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Inspectors found the centre to be visibly clean. Additional measures had been implemented for infection prevention and control due to the COVID-19 pandemic. However, at times, the inspectors found the use of facemasks was not adhering to national guidance.

Judgment: Substantially compliant

Regulation 8: Protection

It was acknowledged that the person in charge was working to improve the protection of residents in this centre. Allegations were treated seriously and investigated in line with national policy, however a number of subsidiary findings of financial safeguarding concern arising from the providers recent reviews are still outstanding. This was in addition to a substantial number of historic concerns.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Grangemockler OSV-0003622

Inspection ID: MON-0029615

Date of inspection: 31/07/2020

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: Schedule 2

A full audit of staff files was completed to ensure that all documents were held in repect of schedule 2. This staff file Audit identified that the discussed ID was not adequate for the purpose it was supplied. The relevant staff member was in the process of supplying an appropriate form of photographic identification. This photo identification is now on file. An audit schedule is now in place for all schedule 2 documents as appropriate and this audit will be overseen and coordinated by the PIC. This audit assures that the following documents are held on file:

• Evidence of the person's identity, including his or her full name, address, date of birth and a recent photograph.
• A vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.
• Details and documentary evidence of any relevant qualifications or accredited training of the person.
• A record of current registration details of professional staff subject to registration.
• A full employment history, together with a satisfactory history of any gaps in employment.
• Correspondence, reports, records of disciplinary action and any other records in relation to his or her employment.
• Two written references, including a reference from a person's most recent employer.
• All documents under Schedule 2 are in place since 3/8/2020.

• Roster review and analysis to be completed by PIC by 31st October 2020 and will gather specific data where volunteers provide core supports to residents.
• National Provider strategy meeting in relation to the role and remit of STCW's scheduled Friday 17th September 2020. The purpose of this review is to develop a national strategy for the reshaping of the volunteer role within CCOI to ensure it functions as an additional resource to enhance Residents life and to support and

maintain the intentional communities of CCOI rather than as a sore support role for communities.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• As part of national improvement actions, CCoI have developed a standard internal audit tool which was utilised in recent unannounced inspections. This will be used in all the communities going forward the tool will be subject to review and improvement.
• A community SharePoint site is in the process of development for Grangemockler creating the infrastructure for increased oversight, where all records are stored, increasing the level of oversight for the PIC at house level, and above.
• Adherence to current policy on the financial policy on how to support residents with their finances is ensured by monthly checks by the PIC.
• Annual review report and the Regulation 23 unannounced inspection will be in place by 30th of October.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• CCoI are implementing new contracts of care, a process of discussion and engagement is taking place with Residents. Families of residents and any responsible signatories will be contacted during this process. New contracts of care will be in place in September 2020.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Policies were in place as required under Schedule 5, however they had not all been reviewed as required by regulation. There was evidence that they were not all consistently guiding staff practice.

1) The CCoI Leadership Team commenced a process of updating overdue policies by on week starting 13th July 2020
2) Revised residents finance policy is complete, the associated SOP is being finalized and will provide a more robust money management assessment, daily and monthly reconciliation and sign off by PIC, with the records being maintained on an electronic system stored on SharePoint. A national implementation plan is currently being developed.
3) The revised contract of care will be in place by September 2020
4) PIC/Quality and Safety Officer walkarounds and spot checks of each house to monitor compliance with policies and procedures.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Revised residents finance policy is complete, the associated SOP is being finalized and will provide a more robust money management assessment, daily and monthly reconciliation and sign off by PIC, with the records being maintained on an electronic system stored on SharePoint. A national implementation plan is currently being developed.
• The PIC will do spot checked that all residents receive a money management assessment, a completed inventory list of possessions supported by an informed risk analysis any ambiguities or high risk assessment will be escalated to the regional manager.
• A schedule of engagement with families is in place to discuss residents assuming rightful control over their bank accounts and finances. Family engagement on this topic has been ongoing to ensure access to Bank statements and oversight.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The PIC has instructed and spot checked that all residents receive a money management assessment, a completed inventory list of possessions supported by an

informed risk analysis any ambiguities or high risk assessment will be escalated to the regional manager.

• A schedule of engagement with families is in place to discuss residents assuming rightful control over their bank accounts and finances. Family engagement on this topic has been ongoing to ensure access to Bank statements and oversight.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• In response to the observed, unsatisfactory use of masks within one house, all staff within the designated center have been instructed to complete the online learning module to help frontline staff implement and adhere to the national standards for infection control.
• All staff to do HIQA national standards for infection control training online by the 30/9/2020.
• The importance of the use of masks and the SOP's relating to fighting the spread of COVID 19 have been discussed with all staff through Community Management Meetings and individual House Meetings.
• PIC/Quality and Safety Officer walkarounds and auditing systems will include weekly inspection on infection control.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC has instructed and spot checked that all residents receive a money management assessment, a completed inventory list of possessions supported by an informed risk analysis any ambiguities or high risk assessment will be escalated to the regional manager.
• A schedule of engagement with families is in place to discuss residents assuming rightful control over their bank accounts and finances. Family engagement on this topic has been ongoing to ensure access to Bank statements and oversight. This process of engagement will support any mitigation of risk in relation to residents finances.
• Subsidiary findings of financial safeguarding concern arising from the providers recent reviews are still outstanding. CCoI have identified some challenges to return the finances to the individual residents who have challenges opening their own bank account. CCoI are working on a solution to ensure the repayments can be made to the relevant

residents into an account that is controlled by the individuals.
• Circle of Support meetings have been established with each resident.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/09/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/10/2020
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	30/09/2020

	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.			
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	31/10/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and,	Not Compliant	Orange	30/09/2020

	where appropriate, the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/09/2020
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/09/2020
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	Not Compliant	Orange	30/09/2020

	necessary, review and update them in accordance with best practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2020