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 Grangebeg
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	22 July 2021
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0032969

About the designated centre

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

Grangebeg Camphill Community has a statement of purpose in place highlighting that it is a residential service inspired by Christian ideals where people of all abilities, many with special needs, can live, learn and work with others in healthy social relationships based on mutual care respect and responsibility. The centre is a registered designated centre to provide residential services to up to 13 residents. It consists of two, three storey premises on a campus, on a farm, which is situated in a rural part of Co. Kildare. Staffing support is provided 24 hours a day, seven days a week by a person in charge, social care workers and social care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 22 July 2021	10:10 am to 7:15 pm	Marie Byrne	Lead
Thursday 22 July 2021	10:10 am to 7:15 pm	Gearoid Harrahill	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 six month improvement plan submitted to the Chief Inspector of Social Services and in the compliance plan following the last inspection in the designated centre in March 2021. The inspection was also following up on unsolicited information in the form of a concern which had been submitted to the Chief Inspector of Social Services.

Overall, the findings of this inspection were that improvements were found across a number of regulations since previous inspections, and residents appeared happy and content in their homes. They were being supported to enjoy a good quality of life, and it was apparent that there was a person-centred approach to the provision of services. The residents were consulted with in relation to the running of the centre and were playing an active role in the decision making within the centre. The provider had implemented the majority of actions from the six month improvement plan and the compliance plan, and was found to be proactively driving improvements in the centre while also appropriately reacting to residents' changing care and support needs. They had plans to take further actions to bring about further improvements in relation to resident's homes and in relation to documentation relating to their care and support needs.

Inspectors had the opportunity to meet and briefly engage with eight of the 12 residents who lived in the designated centre at the time of the inspection. A number of residents were not home as one resident was on a family holiday, and a number of residents were engaging in activities of their choice such as going to day services, or on a trip to the zoo. Residents who spoke with inspectors said they were happy and felt safe in their homes. They talked about people, things and activities that were important to them and about how well they were supported by the staff team in Grangebeg. Inspectors observed warm, kind and caring interactions between residents and staff and warm and friendly interactions between residents in their home.

Throughout the inspection residents talked about things they liked to do and about things they had to look forward to. They talked about regularly engaging in activities they enjoyed, and a number of them talked about the positive impact that the lifting of restrictions relating to COVID-19 was having for them. They were now getting back to meeting with their families and friends and engaging in activities they enjoy in their local community. For example, they talked about going to the gym, swimming, to the bank, to the cinema, or out for a meal. A number of times during the inspection, residents were observed to meet with their peers and staff got a cup of tea or coffee in the main hall on the campus. One resident talked about how important meeting everyone and socialising like this every day was to them.

A number of residents showed inspectors around their home. They talked about things they liked to do around their home such as preparing and cooking the dinner,

doing their laundry and keeping their home clean and tidy. They all said they were very happy living in the centre. A number of residents talked about how good the food was in the centre and about their involvement in preparing and cooking meals regularly. One resident talked about planting, looking after, and then preparing and eating their own vegetables.

A number of residents talked about how important their work on the grounds and on the farm was to them. One resident talked about their love of animals, particularly chickens and bees. They told inspectors about getting their own bee hive and talked about their sense of achievement about this. They had plans to have a party and to cut the ribbon on their hive, and talked about what a special and proud moment this would be for them. Inspectors were also told that a number of residents regularly go to a farmer's market to sell produce from the farm.

Residents described staff as very good, supportive, and nice. Each of them said that the were aware of the complaints process and would feel comfortable going to staff if they had any concerns. A number of residents told the inspectors that the person in charge was leaving at the end of August. They said they were very fond of them and would miss them a lot and talked about the going away party which they had for them.

Inspectors visited both houses in the centre and they were found to be clean, warm and homely. Residents' art work and projects were on display as were their personal and family photos. In one of the houses, there were pictures and a price list for bird houses one of the residents makes. Inspectors saw some residents' work in weaving and pottery on display in the house. Behind both houses were large outdoor space including a winding pathway called the "path of life", a trampoline, swings, and a poly tunnel. There was also a sensory garden which was a project developed by one of the residents. This resident also had future plans to sell some plants they were growing.

Residents' meetings were happening regularly and a number of residents were part of a local advocacy group. At residents' meetings areas such as complaints, safeguarding, menu planning, upcoming events and the day-to-day running of the centre were discussed regularly.

Residents' input was captured as part of the six monthly review by the provider in May 2021. Overall residents were complimentary towards care and support in the centre and stated that they were happy living in the centre. A number of residents talked about some problems they were encountering in relation to sharing their home with other people. However, they all indicated that they were aware of the complaints procedures and had escalated their concerns to the management team. They indicated that overall they were happy with their home, their access to activities, and the level of choice they had in their day-to-day lives.

Residents' representatives' input was also captured as part of this six monthly review. Overall they were very complimentary towards care and support for their loved ones, with a number of stating that their family members were both happy and safe in the centre. They talked about the overall positive experience for their

family members of living in Grangebeg. They were very complimentary towards the staff team and the strong relationships they had formed with residents. A number of them referred to how well the team in Grangebeg had managed to keep everyone safe during the pandemic.

A number of residents' representatives referred to good communication at a local management level but stated that communication could be improved in the organisation at a national level. Some residents' representatives referred to the person in charge leaving and talked about how they hoped that communication and practices remained as good after they left.

In summary, residents appeared comfortable and content in their homes. They were regularly engaging in activities which they found meaningful and were aware of how to raise any concerns they may have. Improvements were found in relation to the majority of regulations since the last inspection and there was evidence of the implementation of a number of systems which were demonstrating the day-to-day oversight of care and support in the centre. Some systems required further time to be fully implemented.

The next two sections of the report will detail 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 designated 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 March 2021 as part of this national monitoring programme of Camphill Communities of Ireland, and at this time a number of improvements were noted in relation to levels of compliance with the regulations. This inspection was completed to verify the actions outlined by the provider in this national improvement plan, and in their compliance plan following the last inspection. In addition, unsolicited information in the form of a concern had been submitted to the Chief Inspector since the last inspection.

In line with the findings of the inspection in March 2021 inspectors found that the provider had continued to bring about a number of improvements. These developments were leading in improvements in the overall levels of compliance with the regulations. The implementation of a number of the provider's new systems was leading improvements in the day-to-day management and oversight of care and support for residents in the centre. Inspectors acknowledge that the provider had further plans to implement a number of further improvements in relation to rosters and care planning, and that some of their systems required further time to be fully implemented.

Areas where improvements were particularly evident related to safeguarding, residents' contracts of care, the management of complaints, the notification of incidents to the Chief Inspector, risk management, and fire precautions. The provider was self-identifying areas for improvement in their latest audits and reviews, such as; staffing numbers, staff training and supervision, and the need for refurbishments to bathrooms in both houses.

It was evident that the local management team had been working on implementing actions from the providers' national governance plan and on implementing the provider's new systems since the last inspection. As previously mentioned, the person in charge had resigned their post and was due to finish in the centre at the end of August 2021. The provider had recruited to fill this position and the person who would be taking on this role was being inducted to the centre at the time of this inspection. The quality and safety lead and an administrator had recently finished working in the centre. The provider had successfully recruited to fill the vacancy for the administration staff and was in the process of recruiting to fill the vacant quality and safety lead post. While waiting to fill this post there was a staff supporting with health and safety in the centre 16 hours per week.

Since the last inspection, the provider had successfully recruited staffing posts and had reduced the vacant staffing complement from 6 whole time equivalent (WTE) positions to 1.5. They had completed a dependency needs assessment for all residents and identified the need for one WTE post to meet residents' current care and support needs. They were in the process of securing funding for this post at the time of the inspection. In filling the 4.5 WTE staffing vacancies, the designated centre had all shifts fulfilled, was less reliant on core staff working overtime hours. The provider maintained a staffing roster which was clear and which identified all personnel on shift and their respective roles. Rosters also clearly identified difference between the contracted and worked hours by staff, and shifts which were covered by the relief panel for the remaining vacancies, annual leave and sick absences. In the sample of weeks reviewed, inspectors found that the service was not reliant on agency personnel to meet residents’ support needs. Inspectors observed staff interactions with residents and found staff to display a good knowledge of residents’ interests, personalities and support needs.

The provider was in the process of developing a system to retain oversight of training and supervision to ensure that these were happening in the manner and frequency set out by the provider's policy. In records provided, the inspectors found that staff had attended formal supervision meetings with their respective line managers and in the case of new members of staff, had undergone performance reviews as part of their probation. Supervision meetings discussed the successes and challenges with staff in their roles, and outlined how they could be supported by their manager to most effectively support residents.

The provider utilised a tracking sheet to highlight where staff were due to attend mandatory training or attend refresher sessions after a specified period of time. While these systems allowed for oversight of a large team of staff, there were some gaps in records of staff training and supervision meetings happening or being scheduled within the stated timeframes. In some instances, the tracker used by the

provider had not been updated to provide an accurate record.

Regulation 15: Staffing

Inspectors found that staffing numbers had increased since the last inspection and that this was leading to improvements in relation to continuity of care and support for residents. 1.5 WTE staffing vacancies remained and the provider was in the process of recruiting to fill these. They had also recently identified the need for another additional one WTE staff in order to meet residents' current care and support needs and were in the process of securing funding for this post.

Improvements had also been made in relation to the maintenance of planned and actual rosters. From the sample reviewed it was evident that each required shift was covered and the name and role of each staff was evident on each roster. Planned and unplanned staff leave was clearly marked on the rosters.

Inspectors reviewed a sample of personnel files and found that they contained the information required by Schedule 2 of the regulations. The provider had completed Schedule 2 audits since the last inspection and was picking up on areas for improvements and taking the required actions. For example, one staff's photo identification was about to go out of date and this had been picked up on by the provider and discussed with the staff member to ensure to get the most up-to-date one on file.

Judgment: Compliant

Regulation 16: Training and staff development

The provider was implementing new systems in relation to the oversight of training and supervision in the organisation. Inspectors found improvements in relation to staff accessing training, refresher training, and supervision; however, there were some gaps in staff attending mandatory training sessions and supervision meetings with their respective line managers, in the timelines set out by the provider.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management and house meetings were occurring regularly and areas such as residents' care and support needs, complaints, incidents, and safeguarding were

being discussed regularly.

Audits were being regularly completed and the provider had recently completed a six monthly unannounced visit to the centre. Overall, the provider was self-identifying areas for improvement and taking the required actions to bring about these improvements. A number of actions remained outstanding in relation to staff training and supervision, documentation relating to residents' care and support needs, and the required works in the premises.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Residents were protected by the admissions policies, procedures and practices in the centre.

Residents had contracts of care in place which contained the terms and conditions, services, fees and additional charges they may incur.

Judgment: Compliant

Regulation 31: Notification of incidents

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

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were protected by the policies, procedures and practices relating to complaints. A number of residents told inspectors that they were aware of the procedure and felt comfortable raising their concerns to staff. A number of them also said they felt that when they raised concerns in the past staff had listened and the required actions were taken.

Judgment: Compliant

Quality and safety

The provider was striving to ensure that residents were in receipt of a good quality and safe service. Residents told inspectors they were happy living in the centre and knew what to do and who to go to if they had any concerns. Residents were observed to receive assistance and care in a respectful, timely and safe manner throughout the inspection. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the person-centred care practices required to meet those needs. However, improvements were required in relation to residents' assessments and personal plan to ensure they were reflective of residents' care current care and support need and were clearly guiding staff to support them. Both the person in charge and one of the persons participating in the management of the centre (PPIM) told inspectors that the organisation had plans to change documentation relating to residents' assessments and personal plans.

As previously mentioned residents lived in warm, clean and comfortable homes. Both houses were designed and laid out to meet the number number of residents and the provider was in the process of supporting two residents to make changes to their bedrooms to better suit their current and future needs. Residents' bedrooms were personalised to suit their tastes and their was artwork, crafting projects and photographs on display in their homes. Residents had access to plenty of private and communal spaces in their home, and to many outdoor spaces. As previously mentioned the provider had plans to make further improvements to the premises such as the renovation of a number of bathrooms.

For a sample of residents, the inspectors reviewed the provider’s assessments of support needs and the personal plans and staff guidance on how to support residents in accordance with their needs, preferences and levels of independence. Overall, personal plans were found to be detailed and highly person-centred, informed by evidence and written in a manner which reflected the residents’ interests, wishes and capacities. Plans provided guidance for staff in supporting residents to communicate, carry out activities of daily living, and manage healthcare needs. Where residents expressed anxiety or distress in a manner which may pose a risk to themselves or others, guidance was provided on how to proactively and reactively respond to the relevant risk. Plans regarding sensitive or intimate supports were written in a manner which respected the dignity and privacy of the resident. There was evidence that plans had been discussed with the resident, and where relevant, the resident was provided with a version of their plan of support which aligned to their communication and capacity, to facilitate them to discuss and consent to their level of support.

While personal plans were detailed and person-centred, the information within was not consistently informed by the assessments of need. In the sample reviewed by inspectors, there were examples of where assessments were not conducted annually or when required, to reflect the most recent evidence. In some instances, the information in the support plans did not reflect the personal social or healthcare needs for which the resident was most recently assessed or the notes from the most

recent reviews. In addition, resident support plans were not assessed on at least an annual basis to determine their effectiveness in meeting their intended objective. Improvement was also required to ensure that discussion meetings between the residents and their respective keyworkers was consistently evidenced, as some residents had no record of meetings with their keyworker in 2021.

Residents were protected by the policies, procedures and practices relating to infection prevention and control. The provider had developed policies, procedures and contingency plans in relation to managing and responding to risks related to the COVID-19 health emergency. The premises was clean and there were systems in place to ensure that personal protective equipment was available. Staff had completed a number of infection prevention and control related trainings.

The provider had responded appropriately to ongoing and incidental risks in the designated centre and had plans set out to address same. Inspectors found evidence of prompt response to adverse incidents, injuries and emergencies, in which said events were used as evidence to update response plans, risk controls and staff guidance. The provider conducted regular unannounced practice evacuations in which efficient evacuation times were achieved. Reports from these drills also highlighted procedures followed and where learning could be taken for future reference. The designated centre premises was suitably equipped with signage and clear evacuation routes, multiple external exits, firefighting equipment and emergency lighting. Doors in the two buildings were equipped with devices which allowed them to be help open where residents wished, without compromising their ability to close in the event of a fire. All personnel were trained in fire safety practices and each shift identified someone to take the lead in the event of an evacuation.

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. For example, staff had completed training, there were safeguarding policy and procedures in place, residents had intimate care plans, and allegations or suspicions of abuse were reported and followed up on in line with the organisational and national policy. Safeguarding plans were developed and reviewed as required. Staff who spoke with the inspector were found to be aware of their roles and responsibilities in relation to safeguarding and in relation to the implementation of residents' safeguarding plans. The provider had completed a serious incident review in relation to residents' finances between 2006 and 2020 and this review was now fully completed. Where residents had been over-paying their fees they had now been fully reimbursed by the provider.

Regulation 17: Premises

The location, design and layout of the centre was suitable to meet the number and needs of residents in the centre. Overall the premises was homely and well maintained. Communal areas were spacious, bright and airy. Residents' bedrooms were personalised to suit their tastes.

As identified in their providers own audits and reviews, 10 bathrooms in the centre required refurbishment. At the time of the inspection, they were in the process of securing the funding to complete these required works.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Residents were protected by the risk management policies, procedures and practices in the centre. There was a risk register which was being regularly reviewed and updated to ensure it was reflective of the actual risks in the centre. General and individual risk assessments were developed and reviewed as required.

Incidents were recorded and reviewed, and learning following these reviews were being shared with the team. Incident reviews were also contributing to the review and update of risk assessments and the risk register.

Judgment: Compliant

Regulation 27: Protection against infection

Residents were protected by the policies, procedures and practices relating to infection prevention and control in the centre. Both premises were clean and there were cleaning schedules in place to ensure that each area of the houses were cleaned regularly.

There were stocks of PPE available and systems for stock control. Staff had completed a number of infection prevention and control trainings since the beginning of the pandemic.

There were suitable facilities for laundry and waste management. The provider has added a number of additional handwashing facilities throughout the centre at entrances and exits to the centre and they had a central access point to ensure that all visitors completed hand hygiene, had their temperature checked and made a declaration prior to visiting either of the houses.

Judgment: Compliant

Regulation 28: Fire precautions

The premises was suitably equipped to detect, contain and extinguish fire and

smoke. The provider conducted regular practice evacuation drills to ensure that efficient evacuation could be achieved by residents and staffing personnel.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Of the sample reviewed, inspectors found examples of where assessments of resident needs were not conducted annually. There were instances in which the assessments of need did not corrolate to staff guidance or support plans to meet resident's personal, social and healthcare needs. Some plans were not reviewed annually, or more frequently as required, to evaluate the effectiveness of the support plans.

Judgment: Not compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre. Further improvements were found since the last inspection in relation to the provider recognising, reporting and recording allegations of abuse. Safeguarding plans were found to be developed and reviewed as required. Staff who spoke with inspectors were aware of the control measures detailed in residents' safeguarding plans.

The provider had finalised the serious incident review in relation to concerns about financial safeguarding for residents in the centre. They had identified that between 2006 and 2020 a number of residents were overcharged fees by the provider. Inspectors viewed documentary evidence to show that each resident who had been overcharged had been reimbursed in full.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community Grangebeg OSV-0003621

Inspection ID: MON-0032969

Date of inspection: 22/07/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • An audit of staff training needs and personal files has been completed by the Quality and safety Lead and Office Administrator on 06.08.21. All required training will be completed by 30.09.21. • All outstanding Schedule 2 documents are being gathered and will be in place by 31.08.21. • The staff rota now reflects the total hours including sick leave and annual leave. • All staff supervision schedule has been implemented to include dates for supervison. • 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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • 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.

• The supervision schedule will be monitored by the PIC through monthly audits.

• Weekly walkaround audits are completed by the House Co Ordinators which reviews systems in place to monitor environmental standards, finance, medication
Residents goal updates and changes in care needs.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A list for the identified upgrades of the bathrooms has been submitted to the properties department and further quotations have been sought from the appropriate professionals for these works.

• A business case will be submitted to the relevant HSE Department to request capital funding for the bathroom upgrades.

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 schedule to commence on 02.09.21 a Comprehensive Assessment of Needs including Multi-Disciplinary input for each resident has been developed by the Quality and safety Co- Ordinator and House Co Ordinators.

• These Assessments will inform the individual support plans for each resident, which will be reviewed with each resident's key worker at key worker meetings.

• The PIC will review the update of each resident's support plan with the House Coordinators at monthly on to one meetings.

• All out of date documentation has been archived.

• An Annual Review with each resident will be scheduled by the PIC and all changes in needs will inform the Support Plan and personal plans including individual goals.

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 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	30/09/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	22/07/2021
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	30/11/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	30/11/2021

	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.	Substantially Compliant	Yellow	22/07/2021
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	Orange	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	Not Compliant	Orange	31/10/2021

	resident which reflects the resident's needs, as assessed in 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)(c)	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 assess the effectiveness of the plan.	Not Compliant	Orange	31/10/2021