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 Jerpoint
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	30 August 2021
Centre ID:	OSV-0003624
Fieldwork ID:	MON-0032353

About the designated centre

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

Camphill Jerpoint provides long term residential care to up to 10 adults, over the age of 18, both male and female with intellectual disability, autism sensory and physical support needs. The centre is made up two detached two-storey houses and apartment each accommodating between one and four residents in a farmyard rural setting. Each resident has their own bedroom and other facilities throughout the centre include kitchens, dining rooms, living rooms, laundries and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (including house coordinators and social care assistants) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Monday 30 August 2021	09:00hrs to 17:00hrs	Tanya Brady	Lead
Monday 30 August 2021	09:00hrs to 17:00hrs	Conan O'Hara	Support

What residents told us and what inspectors observed

This inspection was undertaken to ensure a good quality of care and support was being delivered to residents living in the centre and to consider the renewal of registration of the centre which was due to expire in November 2021. Inspectors sought to verify numerous actions that this registered provider, Camphill Communities of Ireland, had outlined in their six month national improvement plan, as submitted to the Chief Inspector of Social Services, which concluded in April 2021.

The inspection was carried out during the COVID-19 pandemic and as such the inspectors adhered to infection prevention and control guidance such as maintaining social distance and wearing of personal protective equipment (PPE). The inspectors visited all units that make up this centre over the course of the day and completed reviews of documentation in a room separate to residents homes. Inspectors were aware that the provider's clinical team was also present in the centre and were completing reviews of pertinent resident clinical information.

Overall this inspection found that while residents were supported to engage in activities that interested them, and to maintain relationships and contact with families and friends, improvement was still required in key areas such as fire precautions, management of residents finances and management of risks in the centre. Inspectors were required to issue immediate and urgent actions on the day in relation to fire safety and containment systems in the centre.

It was of concern to inspectors that given previous serious concerns relating to fire safety and containment identified in other centres operated by this provider, that a full review and remedial action of fire safety systems had not taken place across all of the providers designated centres. In addition, the fire safety risks identified on the day of inspection had not been self identified by the provider in their own governance and oversight processes, audits or assessments of risk.

There have been two changes in the local management team of the centre since February 2021 in addition to changes in the individuals who are house co-ordinators and in the staff team. These changes have made it difficult for the provider to ensure continuity of care and support for residents. In addition, these changes have posed challenges to introducing and consistently embedding new management and oversight systems.

This centre is registered for a maximum of 10 residents however, is currently home to only nine individuals some of whom were not present on the day of inspection as they were at home with family. Inspectors met with all residents who were present in the centre, with members of the staff team and the management team and spent time with them all over the course of the day.

On arrival inspectors observed that residents were busy and were supported in skills

development including washing a car, maintaining their homes and one resident was gathering ingredients and getting ready to make an omelette. Inspectors were told by residents that they were supported to do things they enjoyed. Two residents were observed making plans with staff and being supported to go for a walk and coffee in the community. Inspectors met with a number of residents who were having a cup of tea with staff in their kitchen prior to going out for a drive in the local area. In addition, some residents were happy to show inspectors around their homes and two residents showed inspectors their art work which was displayed in their homes. One resident made their art into cards which they packaged and sold and had been involved in exhibitions of their work previously. Other residents were wearing team shirts and spoke of sports they watched and liked to support.

However, one resident told inspectors that there have been a lot of changes in the community over the last few months and there had been a lot of staff changes, the resident stated they missed staff that had left and did not like getting to know lots of new people all the time. One resident stated that at night when they were sitting in their kitchen they felt cold and showed the inspector a blanket on their chair, they said they could not turn on the heating. Inspectors acknowledge that the resident had not reported this to staff and this was reviewed by the person in charge on the day.

This centre comprises of three distinct units, two large houses and a single apartment. Within the two houses the provider has subdivided the accommodation so that four residents have self contained living spaces. Inspectors found that residents homes were for the most part clean, warm and homely. They had been personalised with residents' belongings on display in their bedrooms and throughout their home.

In summary, residents appeared to be comfortable and happy in their homes and engaged in activities that they enjoyed. However, inspectors found that the impact of changing staff and management teams, in addition to striving to introduce multiple provider led goals simultaneously had led to increased non-compliance with the regulations since the last inspection.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in this centre and the impact on the quality and safety of the service being delivered to residents.

Capacity and capability

Following a series of poor inspection findings in centres operated by Camphill Communities of Ireland throughout 2020, the registered provider was required to submit a comprehensive national improvement plan to the Chief Inspector of Social Services. As part of this national monitoring programme of Camphill Communities of Ireland this centre was last inspected in July 2020.

Overall, the inspectors found that improvement was required in the effective oversight and governance of the designated centre. There was a clearly defined management system in place and there was evidence that new systems of oversight and monitoring were being introduced.

This had lead to areas of improvement including safeguarding (notwithstanding the ongoing concern in management of resident's finances as outlined below). In addition, the provider was self-identifying areas for improvement in their audits such as staffing numbers, staff supervision and training.

However, the new oversight systems observed were in their infancy and given multiple staff changes had not been consistently applied. The inspectors identified areas for improvement such as fire safety which had not been identified nor risk assessed by the provider. As noted, this was of concern as fire safety systems had previously been identified as an area for improvement in a number of the provider's other centers.

Regulation 15: Staffing

The staffing arrangements required improvement to ensure they were appropriate to the needs of residents and the size and layout of the centre. For example, the staffing numbers had decreased since the last inspection and that staff turnover had increased. The registered provider has identified a requirement for a staff team of 17.5 whole time equivalent (WTE) staff based on the assessed needs of the residents. On the day of inspection, there was a shortfall of 6.3 WTE staff. This meant a third of the staffing complement as identified by the provider was required. Agency staff were used to cover the shortfall in staffing and they were clearly identified on the rosters. While the inspectors acknowledge that the provider was endeavouring to recruit staff, retaining them was an identified concern. Residents who spoke with the inspectors on the day stated that it had been difficult not always knowing who was going to be there to support them, and staff spoken with spoke of the changing staff team dynamics within the houses.

This centre additionally has five short term co-workers or volunteers who live in the centre alongside residents. Inspectors observed that their duties and timetables were clearly displayed and where they were used to provide direct resident care and support this was also clearly identified on the roster.

Inspectors reviewed a sample of personnel files and found that they contained the information required by Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place to monitor staff training and development. A review of a sample of staff training records demonstrated that the staff team had up-to-date training in areas including infection control and safeguarding. However, a number of the staff team required refresher training in de-escalation and intervention techniques and fire safety. This meant that while the staff team had the skills and knowledge to support the needs of the residents some of them required refresher training.

A clear staff supervision system was in place and the staff team in this centre took part in formal supervision. However, the inspectors on reviewing a sample of the supervision records found they demonstrated that not all staff received supervision in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

There had been two changes in the local management team since February 2021 and the person in charge and regional manager had only been in their positions for a couple of weeks prior to the inspection. It was evident that the local management team had been working to implement actions from the providers national governance plan and on implementing new systems that had been introduced since the last inspection. A number of these were not consistently applied due to the agency staff on duty not having access to systems. This had been self-identified as a concern by the provider who was working to amend this.

Audits were being completed and the provider had completed an annual review of 2020 and six monthly unannounced visits to the centre as required by the regulations. The inspectors found that the provider was self-identifying a number of areas for improvement and taking action to bring about these improvements. However, other areas for improvement were not being identified such as the fire safety concerns. In addition, a number of actions remained outstanding in relation to works to the premises, regularisation of amounts paid by residents as per their contract for residential contribution and staff supervision.

Judgment: Not compliant

Regulation 3: Statement of purpose

This is an important governance document that describes the centre's aims and objectives and the services to be provided. This was being reviewed on the day of

inspection to reflect the change in the local management team.

Judgment: Compliant

Regulation 31: Notification of incidents

Inspectors reviewed a sample of incident reports for the centre and found that the Chief Inspector had been notified of all those required by the regulations within the specified timeframe. The inspectors found that tracking systems were in place that ensured all incidents were reported and managed in a timely way.

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, for the most part knew, what to do and who to go to if they had any concerns. Although, some residents stated they were not always familiar with the staff working with them. Residents were observed to receive assistance and care in a respectful, timely and safe manner throughout the inspection. However, improvements were required in relation to the management of residents finances, fire safety in the centre and the identification of risk.

The centre was found to operate in a manner that supported each resident to develop the skills needed to promote their independence. However, the inspectors found some practices relating to the safeguarding of residents personal possessions to be inadequate.

The provider had not ensured effective fire safety precautions were in place, including, fire drills to provide assurance that effective evacuation with minimal staffing could occur. Containment of fire and smoke throughout all three units was of concern and the provider had not completed a review or assessment of fire safety systems within the centre despite concerns having been identified in other centres operated by the provider.

Regulation 12: Personal possessions

The registered provider had systems in place for supporting residents in the management of and safeguarding of their finances. However, the inspectors found

that daily reviews and reconciliations were not happening as per the providers policy. In a sample of residents finances reviewed, the inspectors found discrepancies in the amount of money actually in place against the amount recorded on the daily record. The residents had less money in their wallets than was recorded on the daily system, this appeared to be a result of staff not inputting receipts on the day of a purchase being made. On speaking to staff on duty, inspectors were told that agency staff did not have access to the online system for recording and therefore could not adhere to processes in place for recording and safeguarding finances. It is acknowledged by inspectors that monthly checks by administration staff and spot checks were happening.

Additionally inspectors found that seven of the nine residents in this centre were paying more for their contribution than was outlined on their contract for the provision of care and support on a monthly basis. The discrepancy in amount paid was small but the overpayment had been happening for since January 2020 (20 months) and since the provider had reviewed and put in place new contracts of care for all residents. The provider had identified that this overpayment was happening however, while they had agreed to amend this, it remained outstanding on the day of inspection.

The new management team had identified that some residents had purchased household items such as a dishwasher that should have been supplied by the provider and the inspectors noted that these had been reimbursed in full to the residents involved. The provider and person in charge had been working with residents to ensure that they all had a bank account in their name and access to their money. The inspectors acknowledged that this was a positive area of improvement for residents.

Judgment: Not compliant

Regulation 13: General welfare and development

The residents were provided with access to facilities for occupation and recreation. Residents were supported to participate in activities in line with their interests. On the day of inspection, residents were observed to go for walks and coffee in the community, preparing meals, washing cars and engaging with staff. Residents were also supported to develop and maintain positive relationships with family and friends. On the day of inspection, a resident was observed to return from a visit with their family.

Judgment: Compliant

Regulation 17: Premises

This centre comprises of two large houses and an apartment on a single site in a rural setting. The residential units are within a short walking distance apart and also adjacent to buildings used for activities during the day. There are farm buildings, fields with farm animals and large poly-tunnels and gardens on the site surrounding the residential units.

Within both of the larger houses, the provider has created areas that operate as self-contained units for individual residents. Inspectors found that residents lived in homes that were for the most part clean, warm and comfortable. One resident's home was not as well presented as others and they were supported by staff as they had a substantial volume of personal belongings that they liked to have available to them stacked on the floor. While this was acknowledged as a challenge for the staff team, this residents home was not as clean as other residents.

Within some of the houses, there were rooms not used directly by residents that were part of the designated centre and these contained items in storage or were empty but these had not been included in cleaning schedules and it was of concern. For example, in order top access one room which contained supplies for weaving, people would have to pass through a resident's home.

The provider had completed some refurbishment and decoration of parts of the centre since the last inspection however, areas still required painting and decoration in addition to minor repairs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had risk management policies, procedures and practices in the centre. There was a risk register which, for the most part, was being regularly reviewed and updated. There was evidence that the provider had responded appropriately to incidental risks in the designated centre and had plans set out to address same. However, improvement was required in the identification, management and review of risk. For example, the risk register was not reflective of all actual risks in the centre such as fire safety and management of finances. A small number of general and individual risk assessments had not been reviewed as scheduled in July 2021.

Judgment: Not compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated

with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self-isolation of residents. There was infection control guidance and protocols in place in the centre. There was sufficient access to hand sanitising gels and hand-washing facilities observed through-out the centre and staff were observed to have adequate access to a range of personal protective equipment (PPE) as required. In addition, untreated/harvested rainwater used to irrigate crops grown for consumption by the the residents and staff was assessed. The provider had implemented an alternative system and developed safety protocols for the use of the one remaining water butt.

Judgment: Compliant

Regulation 28: Fire precautions

Immediate and urgent actions were issued in relation to this regulation on the day of inspection.

The arrangements in place for fire safety required improvement. In one resident's living area, the inspectors observed that a fire blanket had been removed from it's mounting and was lying under debris on a counter top. The debris was also lying on top of the cooker hob which could be a source of ignition should the hob be turned on. In the same unit, a fire extinguisher was found to be inaccessible, with piles of residents belongings along the escape route. This escape route ran along the unit with no doors in place to contain a fire from the kitchen.

Inspectors found that the premises were not suitably equipped to contain and extinguish fire. For example,

- In all three residential units inspectors found fire doors propped or wedged open,
- A number of fire doors did not close as required,
- A number of fire doors had been adjusted or had the hardware such as handles replaced in a manner that altered the integrity of the door,
- One resident's utility room door had no self-closing system in place.

Inspectors were also concerned that the doors into attic spaces were not sufficient to contain a fire. In one unit, which was a self-contained apartment set above rooms used for activities, metal ducting ran between floors and it was not clear that these floor breaches were adequately sealed. In the same unit, the inspectors observed that the handrail on the external fire escape stairway was overgrown with climbing plants and therefore not usable.

While there was evidence of fire drills taking place, a night time fire evacuation drill had not been completed to ensure that an efficient evacuation could be achieved by all residents with minimum staffing levels. Inspectors were not presented with any evidence that the fire precautions in this centre had been appropriately reviewed by

the provider.

Judgment: Not compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding and protection in the centre notwithstanding the concerns regarding the safeguarding of finances as outlined under Regulation 12.

Further improvements were found since the last inspection in relation to the provider recognising, reporting and recording allegations of abuse. External reviews of safeguarding practices in the centre had been completed by the Health Service Executive safeguarding team late in 2020. Safeguarding plans were found to be developed and reviewed as required with a number of plans now closed or amalgamated as appropriate.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Jerpoint OSV-0003624

Inspection ID: MON-0032353

Date of inspection: 30/08/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • An assessment of staffing needs has been completed for the community. We are working with our HR department to recruit and allocate staff according to our WTE. We aim to allocate core staff and reduce our reliance on agencies through the recruitment of core and relief teams. • Staffing within the community is reviewed on a weekly basis by House Coordinators, Q&S and PIC to ensure adequate staff are used across the community to meet the needs of the community members. • All staff currently recruited via agency have been trained as per CCOI training requirements. • All staff currently recruited via agency have access to CCOI systems and are inducted fully to meet the needs of all community members. • We are actively engaging with third level colleges to increase our recruitment options for core and relief staff.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All new employees are subject to a robust training induction plan which includes all mandatory training, and an induction into the house each new employee member will be working. • CCOI have implemented a national training tracker which will be in use 04/10/2021 this will identify any staff requiring training.	

• Training has been provided and scheduled for staff in all areas identified to safely meet the needs of the community and community members.
• Refresher training has been scheduled for all staff for continuous personal development.
• Staff are aware of the 2007 Health Act, the Regulations, the Standards - & copies are available across the community.
• All staff receive Supervision in line with Organisational Policy, a schedule is in place and being reviewed by Person in Charge and Quality & Safety Coordinator on a monthly basis.
• The Person in Charge and Quality & Safety Co Ordinator to audit the training and supervision of staff monthly to ensure all training is up to date and valid, this is a standard agenda item on monthly meetings in the centre.
• Fire Marshall training has taken place on 08/09/2021. A further date is booked for 26/10/21
• Risk assessment training is taking place on 01/11/2021
• Additional training will be provided to staff on person centered care and key working. Date to be provided in early November 2021.
• Food safety (HACCP) training has been scheduled for 06/10/2021
• Studio 3 training has been scheduled for 15/10/2021.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A new PIC commenced working in the service on the 2nd August 2021. The PIC has the relevant management qualification and experience required to fulfil the role.
• A New Regional manager, previously PIC in Jerpoint community was appointed into her position on 2nd August 2021.
• There is an operational line management structure in place to oversee the management of the service, this structure supports service delivery from local level to national level across the organisation. The organisation is committed to ongoing oversight completing unannounced visits every six months and conducting an annual review of the service.
• A fire risk assessment was completed on 01/09/2021by CCOI health and safety lead with PIC input.
• An environmental audit was completed by an external Health and Safety auditor on 08/09/2021
• A fire safety audit was completed by an external company on 06/09/2021
• Following each Internal and External announced and unannounced inspections, Annual Reviews and Health & Safety Audits the Person in Charge will ensure that all follow up actions identified are completed in a timely manner and integrated into the Centre's Community Improvement Plan which is maintained on a shared database with oversight from a local, regional, and national level. Progress is tracked on a weekly basis with HC

and Q&S, and monthly with regional manager.
• CCoI has procured a quality management system, commencing with the audit, risk and incident modules. Local H&S and fire management audits will be managed through the system, facilitating increased oversight of the audit schedules and the implementation of the corrective and preventative actions across the organisation. The initial project meeting took place on 8th September 2021.
• The annual supervision schedule is in place for all staff and being reviewed by Person in Charge and Quality & Safety Coordinator on a monthly basis
• Community Management meetings take place fortnightly with Person in Charge, Quality & Safety Co Ordinator and House Co Ordinators to review all aspects care provision to the residents. These meetings have an agenda that includes review of individual resident needs, safeguarding concerns, accidents/incidents, complaints, health and safety concerns, staff training needs and maintenance.
• Monthly Community team meetings with regional manager, clinical team, and regional safeguarding team. These meetings have an agenda that includes review of individual resident needs, safeguarding concerns, accidents/incidents, complaints, health and safety concerns, staff training needs and maintenance.
• Documents are uploaded to SharePoint where the Person in Charge and Quality & Safety Coordinator ensures daily oversight on all records of work completed in each house including residents' daily notes, incidents and accidents and financial transactions pertaining to each resident. Jerpoint SharePoint Site is accessible to and is overseen by the local Management team, Regional Manager and relevant national teams.
• In addition to incident and accidents responded to, reported, and reviewed locally, all reports are circulated directly to the Person in Charge, CEO, Head of Services, Regional Manager and Health & Safety Lead for immediate action and review.
• There is an on-call system in place to provide support to the community when the Person in Charge is off duty.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• All CMSN's have been refunded the amount overpaid and their standing orders have been amended to reflect the correct amount for all community members. On 31/08/2021 CCOI received confirmation via bank statements to show that five out of the seven residents standing orders had been changed to reflect the correct amount. We have received confirmation from family members for the further two residents that their standing order has been changed to reflect the correct amount as outlined in their contracts of care.
• Two community members are still in the process of changing thir DA payment to their own bank account. CCOI continue to support them with this.
• Daily reconciliation of finances are completed on a daily basis as per CCOI policy since the day of inspection. This is overseen by the PIC and House CoOrordinator and signed off by both the PIC and House CoOrdinator daily. This is also audited by the Regional

Manager each month.
• Training has been provided to staff on recording and reconciling of personal finances on 10/09/2021 and on the use of the Sharepoint system on 28/09/2021 to support staff to complete daily reconciliations.
• All agency staff have been given access to CCOI systems in order to complete daily reconciliations.
• Each community member has an up to date personal assets register which is reviewed monthly by PIC.
• Monthly checks and reconciliations are completed on Community members finances locally and randomly by our national team.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Cleaning schedules have been reviewed and additions have been put in place to ensure areas not used are consistently cleaned.
• Areas previously used for storage have been cleared out.
• All maintenance work is identified and reported to the maintenance team where it is prioritised and scheduled.
• The room that was identified to have weaving supplies is for the sole use of the community member who lives at the residence.
• Exposed piping in in one community members home is scheduled for painting to be completed by 08/10/2021
• One remaining apartment will be painted while the community member is on holiday, scheduled completion for 12/11/2021.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The risk register has been reviewed on 02/09/2021 with PIC and Health and Safety Lead ensuring all risks including fire safety and the management of finances have been identified and reflected accordingly.
• All personal risk assessments have been reviewed by PIC by 16/10/2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A Health & Safety Audit was completed by an external contractor on 8th September 2021. Preliminary findings were provided by email by 8th September 2021. All local actions were completed by 13/09/2021 and work instructed to local contractors who are currently in the process of completing the works.

• CCoI engaged an independent contractor who completed a Fire Safety Audit at Jerpoint, on Monday 6th September 2021. The full audit report was received on 14th September 2021 which identified remedial measures required and a priority rating for the works involved. All immediate actions were completed by 08/09/2021.
• An independent contractor has been contracted by CCOI complete the upgrades identified by the audits. This work began on 28/09/2021. Following completion of these upgrades the independent contractor will complete another Fire Safety Audit to certify the completed work meets the regulations.
• Additional funding has been sought through a business case to the HSE.
• On the day of the inspection 30th August 2021 the following actions were completed – Fire blanket replaced on the wall of the one of the homes and clutter removed from access/egress points, and from around fire extinguisher. Additional daily support of this home has been provided by the PIC with the key worker to progress a programme of awareness and support to maintain a clutter free environment, and on the importance of fire safety in the home. New storage has been purchased to support the resident maintain a clutter free environment.
• A twice daily visual inspection has commenced in Jerpoint on 31st August 2021 to ensure fire equipment is accessible, and doors are not propped open.
• Excess materials were removed from attic spaces and storage areas.
• Acoustic door stoppers have also been added at various locations in the community on 6th September 2021.
• CCoI issued a learning and safety notice to all PICs across CCoI on 6th September 2021 to ensure the expected requirements for fire doors is communicated and monitored across all CCoI communities.
• Two fire safety awareness training sessions have been provided to staff and community members on 8th September 2021 covering fire safety awareness, fire management and a review of the issues identified at the recent HIQA inspection.
• Easy read notices were created with the community members on 8th September 2021 and will be displayed in key areas across the community by Friday 10th September 2021, these notices will be shared with all CCOI PICs for use in their communities.
• Following the inspection on 30/08/2021 additional night-time fire drills were completed throughout the community.
• Repeat unannounced night-time drills have been scheduled across the community to be completed by 5th October 2021 when all residents are present.
• All community members PEEP's have been updated by PIC following above fire drills. They have been circulated to all staff across the community and are discussed at weekly house meetings.
• Evacuation procedures have been reviewed by PIC for each house and circulated to all staff.

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	29/10/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2021
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	29/10/2021

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
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	29/10/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	29/10/2021
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	29/10/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	29/10/2021
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	29/10/2021

	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 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	29/10/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	29/10/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	29/10/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	29/10/2021
Regulation 28(3)(d)	The registered provider shall	Not Compliant	Orange	29/10/2021

	make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	29/10/2021