<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Camphill Communities of Ireland</th>
</tr>
</thead>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003610</td>
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<td>Centre county:</td>
<td>Wexford</td>
</tr>
<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>Camphill Communities of Ireland</td>
</tr>
<tr>
<td>Provider Nominee:</td>
<td>Adrienne Smith</td>
</tr>
<tr>
<td>Lead inspector:</td>
<td>Noelene Dowling</td>
</tr>
<tr>
<td>Support inspector(s):</td>
<td></td>
</tr>
<tr>
<td>Type of inspection</td>
<td>Announced</td>
</tr>
<tr>
<td>Number of residents on the date of inspection:</td>
<td>28</td>
</tr>
<tr>
<td>Number of vacancies on the date of inspection:</td>
<td>1</td>
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About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider’s compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority’s Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

**The inspection took place over the following dates and times**

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>16 September 2015 09:30</td>
<td>16 September 2015 20:00</td>
</tr>
<tr>
<td>17 September 2015 08:30</td>
<td>17 September 2015 19:00</td>
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The table below sets out the outcomes that were inspected against on this inspection.

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
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<tr>
<td>Outcome 02: Communication</td>
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<td>Outcome 03: Family and personal relationships and links with the community</td>
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<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
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<td>Outcome 05: Social Care Needs</td>
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<td>Outcome 06: Safe and suitable premises</td>
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<td>Outcome 07: Health and Safety and Risk Management</td>
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<td>Outcome 08: Safeguarding and Safety</td>
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<td>Outcome 09: Notification of Incidents</td>
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<td>Outcome 10. General Welfare and Development</td>
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<td>Outcome 11. Healthcare Needs</td>
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<td>Outcome 12. Medication Management</td>
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<td>Outcome 13: Statement of Purpose</td>
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<td>Outcome 14: Governance and Management</td>
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<td>Outcome 15: Absence of the person in charge</td>
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<td>Outcome 16: Use of Resources</td>
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<td>Outcome 17: Workforce</td>
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<td>Outcome 18: Records and documentation</td>
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**Summary of findings from this inspection**

The purpose of this inspection was to inform the decision of the Authority in relation to the application by the provider to have the centre registered. All documentation required for the registration process was provided with the exception of compliance with the planning department.

This was the second inspection for this centre which provides long term residential services to people with intellectual disability, people on the autism spectrum and physical and sensory disabilities. Service is provided to 29 residents. Funding for the service is via the Health Service Executive (HSE) under section 39 of the Health Act, 2004, voluntary fund-raising, and residents’ own contributions.
On the days of the inspection there were 28 residents living in the centre and the provider had applied for registration for a total of 29 residents with two premises allocated for single occupancy.

Inspectors also reviewed the actions required from the previous inspections which took place in June 2014 were also reviewed. A total of 34 actions were required. Some of the actions were interconnected including fire safety procedures and risk management.

In total ten of the actions had been addressed satisfactorily, some improvements were evident in 18 actions and six actions had not been satisfactorily addressed. The actions not addressed included significant works such as fire safety, safeguarding training for staff and risk management procedures. Additional actions were required in safeguarding procedures.

An immediate action plan was issued to the provider in relation to fire training for a significant number of staff. The provider’s response was timely and the Authority was informed that 59 out of 73 staff had undergone training between the 19 and 21 of September 2015 in response to the action. A further date was scheduled to complete the staff group.

Inspectors met with residents and staff and observed practices. Inspectors also reviewed four questionnaires completed by residents or their representatives. All of the responses were very positive regarding the quality of their lives, their feeling of safety and the choices they had available to them in their daily lives. Inspectors reviewed documentation including policies and procedures, personnel files, health and safety documentation and resident’s records and personal plans. As part of the registration process inspectors met with the person in charge and the provider.

The findings of this report are influenced by a number of factors including:
- lack of stable local management in the preceding twelve months
- significant changes to the dependency levels and complexity of residents needs
- changes to staffing structures
- lack of clarity as to local management responsibilities.

The centre is therefore in a significant period of transition.

The inspection found that the service was managed and operated in a manner which prioritised the needs and wishes of the residents. Their views were actively elicited and acted upon. There was a significant emphasis on their right to make choices and remain as independent as possible with supports as required. Residents had access to meaningful activities in an inclusive environment. Complaints were managed transparently.

Improvements were required in the following areas:
- fire safety procedures and management required significant review
- fire safety works were required to be undertaken in the premises
- safeguarding systems
- risk management procedures
- residents’ personal plans did not consistently demonstrate adequate review or
multidisciplinary involvement
• recruitment procedures were not robust
• staff training in crucial areas including fire safety and the protection of vulnerable adults was not satisfactory
• responsibilities and duties of volunteer staff.

These issues are covered in more detail in the body of the report.

The Action Plan at the end of the report identifies areas where improvements are needed to meet the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) With Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.
**Section 41(1)(c) of the Health Act 2007. Compliance 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.**

**Outcome 01: Residents Rights, Dignity and Consultation**

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident’s privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

**Theme:**

Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that there was commitment to promoting and supporting residents’ capacity to exercise personal choice, maintain their dignity and ensure they were involved and consulted in their day-to-day lives and care. The residents who could communicate with the inspectors indicated a significant level of satisfaction with their quality of life at the centre as did the questionnaires received.

The statement of propose states that one of its aims is “to promote a fulfilling lifestyle within a life sharing residential community” and there was evidence that this was actively promoted and understood by both staff and management in the day to day care at the centre.

There was evidence that residents and their representatives were involved in their personal planning, and choosing their own activities and personal goal’s and their annual reviews. There was good communication evident between the co-workers/staff and the residents. Staff were seen to speak with residents warmly and respectfully. Residents’ meetings had commenced and the records reviewed indicated that their views on routines, activities, recreation were elicited and their preferences acted upon.

Advocacy services had been sourced for the residents where this was necessary. Residents were encouraged and supported to remain in control of their own finances where this was deemed appropriate but suitable records of spending on behalf of residents had commenced in the individual houses.

Residents attended religious services in the local community and non denominational services were held within the campus.

There was sufficient transport available and staff were consistently available to
accompany residents to local events. Residents had been registered to vote and a small number did so in the local community. There was a policy on personal property and finances and inspector saw detailed lists of personal belongings.

Staff were observed being sensitive to residents need for privacy and personal space. Bathrooms had suitable locking mechanisms. There was a written operational policy and procedure for the making and management of complaints which was in line with the regulations. The policy included an external appeals process, overview by the provider and encouraged local and immediate resolution where this was feasible. There were time-scales and responsibilities outlined. A pictorial synopsis was posted in a suitable area of the premises. Residents who could communicate with the inspectors said they felt they could tell anyone and in particular named the house coordinators, about any complaint and it would be listened to. From a review of the complaints records available inspectors were satisfied that the process was fully transparent.

**Judgment:**
Compliant

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**Outcome 02: Communication**

*Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that the diverse communication needs of the residents were supported by staff who were knowledgeable of their verbal and non-verbal communication and able to communicate effectively with them. Residents’ personal plans held detailed communication needs analysis and guidelines for staff in the use of visual aids and sign language, which a number of staff were familiar with. A staff member helped the inspector to communicate with a resident using this medium.

Residents' non verbal communications were also observed to be understood by staff.

**Judgment:**
Compliant
**Outcome 03: Family and personal relationships and links with the community**

*Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.*

**Theme:**
Individualised Supports and Care

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Inspectors were satisfied that familial relationships were maintained and supported via regular visits home and to the centre and via letters and phone call. Although inspectors met with no relatives during the process other information received from relatives indicated that they were consulted, involved and informed of any incidents which occurred. There was also evidence that they attended the annual reviews of the residents.

**Judgment:**
Compliant

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**Outcome 04: Admissions and Contract for the Provision of Services**

*Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.*

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Inspectors were satisfied that the action required from the previous inspection had been satisfactorily addressed and a contract for the provision of care and the services to be provided was issued to the resident or their representative for signing. There was a detailed policy on the procedure for admission detailing how the admission process would protect residents from abuse by their peers and sourcing of all relevant information.

A review of the records in relation to the most recent admissions indicated that the process was not managed as outlined in the policy. Pertinent information had not been made available to the person in charge from the admitting service. This was not however, due to failure on the providers part.
There was evidence of pre-admission visits undertaken to give the residents or their representatives an opportunity to decide if the placement was suitable. The visit including sharing meals, meeting with other residents and staff and staying overnight. A trial period of twelve weeks was undertaken and this was made clear to all concerned. This was in process for the recent admissions.

There was detailed transfer information available should a resident require transfer to acute care services.

**Judgment:**
Compliant

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**Outcome 05: Social Care Needs**

Each resident’s wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident’s assessed needs are set out in an individualised personal plan that reflects his/her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

**Theme:**
Effective Services

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There were six actions required following the previous report in relation to personal plans and the holding of multidisciplinary annual reviews. It was apparent that remedial actions had commenced on all of these but the documentation did not fully demonstrate compliance. From a review of eight resident’s records there was evidence that all residents had very detailed personal plans documented with the views and aspirations of the residents included.

The plans demonstrated a very comprehensive knowledge of the residents’ social health and psychosocial needs and how to support them in all aspects of daily living including personal care, travel, shopping, money management, friendships, communication family contact, and mental health. However, some of the plans did not contain time-scales or allocated responsibility for ensuring they were acted upon.

While a system of annually reviewing the residents’ personal plans had been undertaken as required the reviews of the plans did not consistently demonstrate that they were multidisciplinary or the interventions of allied disciplines were included. They did not consistently demonstrate that the goals were implemented, had been effective or who
was responsible for doing so. For example, a basic goal for one resident was that he would have regular access to walking a dog each week. There was no evidence of this being undertaken although staff confirmed that it was.

In another instance a residents loss of hearing was not referenced in the plan and review despite the identified need for a hearing test. This also applied to more significant issues such as access to multidisciplinary services. In one instance the minutes of a review meeting were available but no plan had been devised. In the inspector's view this may be caused by staff requiring further training in the process of implementing and reviewing personal plans.

There was, however evidence of relevant multidisciplinary involvement in residents' care including good access to speech and language therapy, physiotherapy and dieticians.

While assessments were undertaken on the residents these were not consistently undertaken using the available evidence based tools. Although the inspector acknowledges that in some instances they were very thorough. However, a falls risk assessment seen did not accurately reflect the resident's status and take account of the location of the resident's bedroom upstairs in terms of risk. There was no specific plan for clinical care needs for a resident to guide staff where this would have been required.

It was of some concern that in some instances the interventions of some clinicians appeared not to be given due consideration in the minutes of a review held. For example, in one record seen the advice of the psychology/psychiatric service appeared to be overridden by the staff who wrote the minutes. Inspectors acknowledge that some of the deficits outlined above are documentary they cannot all be explained by this.

The process of making the personal plans available in an acceptable format had commenced and those seen in this format were person-centred and a resident outlined the details of her plan to the inspector. It was evident that the residents and their representatives had significant input in relation to the plans.

Resident had access to social and meaningful activities of their choosing based on their preferences. These included participating in the farm work, gardens, caring for the animals, weaving and craft making.

They also took part in horse riding, and attended swimming and leisure clubs; the local seaside or the cinema in local towns and had regular visits home. While there were routines and a structure to the daily life of the centre there was also significant choice for the residents in how they spent their day and where they did so.

They participated in the daily life of the houses, for example they helped with laundry, cooking and undertook general housekeeping chores to promote their independence, a sense of active participation and inclusion in the life of the centre. They told inspectors this was important to them.

Judgment:
Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The centre is located in a rural coastal area accessed from the road via a driveway. There are a number of ancillary buildings located in amongst these premises including a workshop building, a store, farm building and animal shelters. A meeting/community hall and weaving centre is onsite. The residential accommodation for which the application is made is comprised of eight houses with one stand alone apartment attached to one of the houses. Administration offices are located in the largest of the houses.

There are three bungalows, some split level, four two story buildings and one three story building. The accommodation for staff/volunteers and residents is interspersed throughout each of the houses on various levels. The houses accommodate between one and five residents and varying numbers of volunteers co-workers. One of single occupancy houses was not occupied at the time of the inspection.

Some of the houses were older than others and therefore require considerable upkeep and maintenance. The action required from the previous inspection was that a schedule of maintenance and repair be implemented and this had been undertaken. Some areas still showed evidence of damp however.

The provider was in the process of renovating two bathrooms to make them suitable for residents with diminished mobility. There were a suitable number of bathrooms and toilets in accessible areas for use. The equipment including specialist beds and a hoist had been serviced as required. Heating systems were also serviced regularly.

The premises were homely and met the needs of residents in general. There was suitable furniture, comfortable seating and resident’s art work, books and hobby equipment evident. Generally the décor, design and layout were compatible with the aims of the statement of purpose with some improvements required in painting and decorating on an ongoing basis. Due to the design and layout of the premises the provider will be required to ensure that residents accommodated on the first or second floor of any of the houses can safely access the stairs and the bedrooms as their needs change.
There were adequate sitting, recreational and dining space separate to the residents’ private accommodation and separate communal areas, which allowed for a separation of functions and there was space for private time and visits. Residents that showed inspectors their rooms stated that they were happy with the living arrangements and most had personalised their rooms with photographs of family and friends and personal memorabilia.

Records also showed that the vehicles had evidence of road worthiness and the heating was serviced regularly. There were garden areas outside which contained flower beds, vegetable gardens and seating. A variety of pathways were available to negotiate the grounds between the houses. These were seen to be accessible to and used by the residents'.

The inspectors noted that some furnishings including beds, wardrobes and linens required replacement. The single story house which was unoccupied required remedial works in relation to weeds and undergrowth to be removed before it could be occupied by a resident.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There were ten actions required following the previous inspection. None had been fully resolved. The risk management policy had not been revised as required. However, there was a risk register in place detailing the precautions necessary for events such as residents going absent, self harming and accidents and incidents. There was a policy on resident’s absence without leave. An emergency plan was in place and this included arrangements in the event the centre had to be evacuated.

There was a current and signed health and safety statement available. A twice yearly annual health and safety audit of the various components of the service including the garden, the houses and work practices was undertaken by an independent safety officer each year.

Accident and incidents were recorded and reviewed at the local risk management forum. There was evidence of review and learning and remedial actions taken with root cause
Despite these systems there were deficits in the consistent identification and management of risk. This is evidenced by a number of findings including the significant deficits in fire training for staff which the provider was given an immediate action plan for. Inspectors viewed training records provided by the centre that showed that out of seventy-six staff only sixteen had received mandatory fire training in the past twelve months. This action plan and the provider’s response is incorporated into this report.

At the last inspection in May 2014 the provider had a fire safety assessment and a risk report in relation to the fire safety of the premises. This was initially undertaken in order to achieve a certificate of compliance with the fire safety authority. Although this certification is no longer required for registration purposes the significant works are still required to ensure the safety of the residents in these premises. The provider had stated that they would be completed by September 2015. At the time of this inspection the works had not commenced although the provider stated that they had been tendered for.

The inspector requested to see the fire safety risk assessment prepared by the consultant which was forwarded following the inspection. A number of risks including the installation of necessary fire doors in crucial areas were red risk rated and required to be actioned within a three month period. This had not been undertaken.

Many final exit doors were secured with keys. None of these doors checked by inspectors had a key located in a break glass unit adjacent to the door for use in the event that the person using the door to evacuate did not have a key.

There were fire evacuation notices and fire plans publicly displayed in each premises. Fire drills which included residents were held twice yearly. However, inspectors viewed records showing that an evacuation of one house took in excess of eight minutes and, while the outcome was discussed subsequently, another fire drill did not take place for a further four months to remedy the delay.

While most staff were able to inform inspectors what they should do in the event of fire one staff did not know what number to ring in such an emergency. Fire marshals were assigned to each unit to monitor exits and the fire alarm but these were not documented consistently in each house. Fire safety awareness training was included in the induction for new co-workers.

There were individual evacuation plans for residents available. However, these did not demonstrate that the location or dependency levels of the residents had been considered. For example, one maximum depended resident was to be evacuated via hallways and the hoist used to place her into a chair. The nearest evacuation point to the resident was bypassed in the plan. Another resident’s evacuation plan did not take account of the location of his bedroom and his mobility status while another was dependent on one specific staff member being available to transport the resident.
Maintenance records for fire equipment including the fire alarm system, fire extinguishers and fire blankets were available. Servicing records for emergency lighting could not be provided.

There were individual risk assessments compiled for residents which included the risk of falls, going missing or ingesting materials. These outlined the strategies to take to prevent such an event and to manage it if it occurred. Some effective strategies were used including the use of non-slip mats or rugs to prevent injury in the event of, for example, a seizure. Alarms were also used to alert staff to residents at risk of falls or seizures. Additional supervision was indicated for a number of residents and this was provided.

However despite the identified risk of residents ingesting chemicals there was an incident where a resident gained access to a cleaning chemical which had not been stored safely. A plan for the use of a full body hoist for one resident indicated that that two staff were required to use this safely. This was not consistently applied. The risks from the stairs/banisters identified at the previous inspection had been reviewed with two of the banisters raised.

There was a missing person profile including a good sized photograph of the resident available should this be required but this was not available on all records seen by inspectors. Policy on the prevention and control of infection was satisfactory but core elements such as the availability of hand sanitizers were not available where this would be deemed necessary.

Judgment:
Non Compliant - Major

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<th>Outcome 08: Safeguarding and Safety</th>
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<td>Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.</td>
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| Theme: |
| Safe Services |

| Outstanding requirement(s) from previous inspection(s): |
| Some action(s) required from the previous inspection were not satisfactorily implemented. |

| Findings: |
| Inspectors were satisfied that resident’s safety and welfare was prioritised but some |
Improvements were required in training for staff and in robust adherence to correct and comprehensive processes when concerns were raised.

There were detailed statements available to the residents and the bank card was held securely with the resident consent. Inspectors found that all expenditure including fee payments and other expenses incurred were detailed and carefully receipted. Residents had choice in how they spent their monies and it was easily available to them for day-to-day expenses with the support of staff where this was required.

Inspectors were informed that the provider was not acting as agent or guardian for any residents at the time of this inspection. However it emerged that a financial institution had proceeded to act as agent for seven residents’ funds without due authority. This had resulted in the residents not having access to their monies and the provider having to invoice the bank for all of their needs. This remains to be resolved by the provider.

Inspectors reviewed the policy and procedure on the protection of vulnerable adults and found that it was in accordance with the revised policy issued by the Health Service Executive in 2014. However, training for staff had not taken place in a significant period of time.

The organisation had set up a safeguarding team with a person designated at national level to undertake any investigations should an allegation occur. There was also a centre based designated person appointed.

Inspectors examined the actions taken and investigative process used in response to a recent allegation made. Inspectors were not satisfied that appropriate protective systems had been put in place in a timely manner for all residents in the intervening period. The screening/investigation and reporting process was limited in its scope and did not follow the guidelines.

Additional risks were identified in the recruitment process where documentation was not satisfactory, information was not verified and significant gaps were noted in the information provided by staff prior to taking up either voluntary work or employment in the centre.

During the course of the investigation there was also evidence that a historical allegation made some years ago had not been investigated at all by the organisation. Further training education was required for all parties in the safe and effective management of allegations and preventative systems.

Staff and volunteers spoken with demonstrated an understanding of their own responsibilities in relation to the protection of residents and signs and symptoms of abuse which would indicate concern. They also expressed their confidence in co-workers/staff and the person in charge to act on any concerns which may arise.

There were a number of children residing with their parents in the community. The Children First policy was available and safeguarding systems had been undertaken in relation to this.

There was a lone working policy available. There was a policy on the provision of
intimate care and support to residents which indicated that gender preferences, consent and privacy should be considered and details of these were available in the personal plans seen by inspectors. From speaking with staff and residents the inspectors were satisfied that the matters were considered in practice.

Residents who could communicate informed inspectors that they felt very safe and well cared for in the centre. They were also aware of things which should not happen to them such as someone hitting them and that they had the right to say yes or no. They also said that the number of people on the campus made them feel safe.

There was a policy on the management of challenging behaviours which was not satisfactory to guide practice. However, the guidelines available for the use of restrictive practices was comprehensive and in accordance with national guidelines. The actions required from the previous inspection in relation to the assessment for the use of bed rails and lap belts had been resolved.

There was assessment of need undertaken and these were reviewed. However the safety aspect of the usage of bed-rails was not assessed. For example the safety and condition of bed rails was not regularly checked and staff had been using cushions placed near residents' heads to prevent residents from injuring themselves on the rails. This presented a significant safety risk to the resident. This is actioned under outcome 7 Health and Safety and Risk Management. A number of residents had behaviour support plans in place which were detailed and supportive. Innovative strategies including facilitating residents to live in single occupancy arrangements had been implemented to good affect. These were not restrictive arrangements however. No other restrictive practices were used and there was evidence that medication was not used to manage behaviours.

**Judgment:**
Non Compliant - Major

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### Outcome 09: Notification of Incidents

_A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector._

**Theme:**
Safe Services

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
The inspector found that the provider had complied with the responsibility to forward the required notifications to the Chief Inspector. Incident reports were reviewed by the person in charge and house coordinators and actions were taken where these were necessary.
**Judgment:**
Compliant

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**Outcome 10. General Welfare and Development**

*Resident’s opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
No actions were required from the previous inspection.

**Findings:**
Residents’ opportunities for new experiences, social participation, training and employment were facilitated and supported according to their needs and abilities.

There was a suitable policy in relation to education training and development made available to inspectors. Inspectors observed that residents received practical training in horticulture, food preparation, agriculture and animal care. The crops harvested were used in food preparation and residents were very proud of their achievements and contributions.

Residents engaged in social activities internal and external to the centre. Residents with whom inspectors spoke outlined trips to the cinema, bowling, dances and places of local interest. A number of residents participated in the Special Olympics.

Residents enjoyed participating in sports such as swimming in local leisure centres. Residents' participated in range of varied interests within the centre during the day such as horse riding, art, crafts, woodwork, cooking and horticulture. A number of residents were attending literacy classes.

Inspectors did find that a formal assessment of residents’ education, training and development needs was lacking. This assessment would ensure that goals relating to education, training and development were developed in accordance with each resident's ability, talents and preferences. However inspectors were satisfied that the staff were very aware of the resident’s capacity and interests and acted upon this.

**Judgment:**
Compliant
### Outcome 11. Healthcare Needs
*Residents are supported on an individual basis to achieve and enjoy the best possible health.*

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**
Residents' overall healthcare needs, including nutritional needs, were met and residents had access to appropriate medical and allied healthcare services. However, improvements were required in the consistent and timely access to GPs, documentation of these visits and implementation of protocols to support specific healthcare needs.

Inspectors reviewed a sample of eight residents’ files and there was evidence of timely and frequent access to their general practitioner (GP) in most but not all cases. In one instance the records demonstrated that staff administered pain medication for six days to a resident who was unable to verbalise his complaint. Staff were not familiar with the resident’s full medical history. Access to the GP was not facilitated.

It was not always apparent whether the records of medical appointments were documented by the accompanying staff or the GP. In addition, some records gave contradictory information on resident’s medical care needs therefore did not sufficiently guide practice. In one instance written by staff the record stated that a prescribed medication had been replaced by a homeopathic substance. On enquiry inspectors found that this was not accurate.

Where a specific care plan for healthcare needs was required it was not in place and staff aside from the house co-ordinator were not sufficiently familiar with the protocol required. In the inspector's view these findings are related to the lack of adequate oversight of the delivery of care at a local level.

In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists, dentists and chiropodists. Records of referrals and reports of these interventions were maintained in residents’ files.

There was evidence that where treatment was recommended and agreed by residents this treatment was facilitated. Residents’ right to refuse medical treatment was also respected. There was evidence on documentation that residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. A protocol was in place for the management of epilepsy and emergency medication.

Inspectors saw that residents received increased support at times of illness and increased dependency. In response to changing needs additional waking night staff had...
been provided and equipment such as pressure relieving mattresses and cushions were sourced. Inspectors noted that the healthcare plans for residents whose needs were changing were especially detailed and there had been advice sought from the public health nurses and geriatrician in relation to their future care needs.

A policy on end of life care had been implemented as required to guide staff in meeting residents’ physical, emotional, social and spiritual needs for end of life care. Due to the recent deterioration in some residents’ health the co/ordinator informed inspectors that while no documented decisions or consultation had as yet taken place meetings were being scheduled to ascertain the residents and relatives wishes. Access to palliative care was available as and when required.

The policy on end of life care states that where nursing care is required this would be facilitated at such times in order to facilitate residents to remain in their own home.

Inspectors observed that residents were encouraged and enabled to make healthy living choices in relation to exercise, vaccination and healthy eating habits. One resident explained her dietary requirements to the inspectors and was very pleased that she had lost weight.

A number of residents required their meals in modified or altered form which had been prescribed by the speech and language therapist. The action from the previous inspection had been addressed and staff were aware of the dietary needs and how to implement them. Inspectors observed that there were ample quantities of food and drink; that was properly and safely prepared, cooked and served.

Many of the fruits and vegetables used to prepare meals had been grown by residents on the farm. Residents participated in the preparing and cooking of the meals. An inspector joined residents staff and volunteers for tea which was a relaxed and very interactive social occasion with all residents included.

A number of residents were supported in preparing helping staff to cook the food and there was adequate provision to store food in hygienic conditions.

**Judgment:**
Non Compliant - Moderate

**Outcome 12. Medication Management**
Each resident is protected by the designated centres policies and procedures for medication management.

**Theme:**
Health and Development

**Outstanding requirement(s) from previous inspection(s):**
The action(s) required from the previous inspection were satisfactorily implemented.
Findings:
The action from the previous inspection had been satisfactorily addressed. There was identification of medication on each of the medication dispensing blister packs.

Medication to be administered in an altered format was prescribed and the administration records seen by the inspectors had been signed by the staff who administered it. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines.

Staff/co-workers demonstrated an understanding of medication management and adherence to guidelines and regulatory requirements. Residents’ medication was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. Inspectors saw and staff/co-workers confirmed that medicines requiring refrigeration or additional controls were not in use at the time of inspection.

A sample of medication prescription and administration records was reviewed by inspectors. Medication administration sheets identified the medications on the prescription sheet and allowed space to record comments on withholding or refusing medications. However, medication prescription records available did not consistently correlate with the medication being administered. The person in charge clarified this during the inspection and there was no adverse impact for the resident who was receiving the correct medication.

There was evidence that residents were offered the opportunity to take responsibility for their own medicines and assessment was undertaken to ascertain this. The medication management policy outlined the procedure for completing a risk assessment and assessment of capacity prior to residents self-administering and managing their own medicines.

Staff outlined the manner in which medications which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and returned to the pharmacy for disposal. Training had been provided to staff/co-workers on medication management.

Judgment:
Compliant

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
The statement of purpose had been forwarded to the Authority as part of the application for registration and an amended version was forwarded at the time of the inspection. Admissions to the centre and care practices as seen were congruent with the statement of purpose. This will be required to be kept under review in relation to the changing needs of the residents and the arrangements to meet these needs.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
Inspectors found that while there were governance structures in place improvements were required to ensure they were effective and to define the roles and responsibilities. The person in charge of the centre had taken up post three weeks prior to the registration inspection. She had considerable experience in nursing and in services for persons with disabilities and mental health. This was pertinent to the statement of purpose for the centre and the current needs of the residents. She was full time in post and was seen to be fully involved in the day to day and strategic operations of the centre although new to the post. Residents were becoming familiar with her. She was also taking steps to ensure she was familiar with the regulations and standards required for the service.

A range of governance meetings were undertaken and reporting structures were evident. However, the findings in relation to risk management, safeguarding, social care and health care indicate that the systems do not currently ensure safe and effective service provision. The systems for overseeing care practice and delivery were also not robust.

In discussion with inspectors the provider nominee demonstrated her awareness of
these factors and had taken steps including the appointment of the person in charge, additional staffing which included trained paid staff to address them. The nominee of the provider demonstrated an awareness of the responsibilities of her role.

As required by the regulations the provider had two unannounced visits to the centre and a detailed report of the findings was compiled. The detail was comprehensive and formalised to ensure critical elements of quality and improvement were included. The provider showed the inspectors’ a detailed survey designed to include residents views in the overall annual review which had not as yet been implemented. There were audits on incidents and accident undertaken. A formal system of compiling information on accidents and incidents had been commenced in order to ensure that information was available. There were other avenues including the residents meetings and day-to-day consultation to ensure resident’s views were heard in relation to the service provided.

Evidence of compliance with the planning authority was outstanding for the application for registration.

Judgment:
Non Compliant - Moderate

**Outcome 15: Absence of the person in charge**

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**

No actions were required from the previous inspection.

**Findings:**

There was a suitably qualified and experienced senior co-worker assigned to take on the duties of the person in charge during any periods of extended absence and periods of annual leave. The person was assigned the duties of the person in charge and was fully involved in the management of the centre on an ongoing basis. All relevant documents had been forwarded to the Authority and the arrangements were satisfactory.

**Judgment:**
Compliant
### Outcome 16: Use of Resources

*The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.*

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<tr>
<th>Theme:</th>
<th>Use of Resources</th>
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#### Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

#### Findings:
The provider has demonstrated that there are sufficient resources to provide sufficient care for the residents with suitable facilities, staffing and transport available. Resources were increased in response to need, as evidenced by the increase in the staffing levels to provide one-to-one care for a number of residents.

The lack of action in relation to the necessary fire safety works however indicates that the financial resources available to the provider may not be sufficient to undertake works requiring such expenditure.

#### Judgment:
Non Compliant - Moderate

### Outcome 17: Workforce

*There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.*

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<tr>
<th>Theme:</th>
<th>Responsive Workforce</th>
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#### Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

#### Findings:
The workforce in the centre was a combination of short term volunteers, house coordinators/long term volunteers and paid members of staff in accordance with its function and model of care. The provider had in the preceding months increased the number of paid staff available and one to one supports for residents as a response to changing and increasing needs. This included waking night staff in three houses. These were significant departures for this centre.
Measures including the employment of a suitably qualified nurse as the person in charge was also responsive to this changing need. Inspectors found that the numbers and skill mix were currently satisfactory. The provider was aware that these may require further review.

Inspectors found that the staffing structure has been somewhat informal with a lack of clear responsibilities outlined for the volunteers. This was evidenced by the rosters available in some of the houses. Some of the staff informed inspectors that it was up to them to decide who was available /responsible for sleeping duties in the units at night as opposed to a formal rostering system. These are historical practices but present a risk to the safety of residents.

There was also a dependence on the co/coordinator to devise and implement the residents' personal plans and to be the only persons who are responsible for this.

All long-term co-workers/staff had a range of suitable and diverse qualifications which were pertinent to the residents' needs. These included social care and therapeutic interventions for persons with disabilities.

However, internal training was not satisfactory. The inspectors saw the records of mandatory training including the protection of vulnerable adults, manual handling and fire safety training. Manual handling training was out of date and MAPA (Management of Aggression and Violence) training was out of date for a significant number of staff. Inspectors acknowledge that the training records may not have been updated or current but these are still significant deficits. Given the changing needs of the residents consideration should be given to training/education for staff in supporting residents with dementia.

Co-workers/volunteers were recruited from a number of oversees agency's who specialise in training and support of volunteers. There was a detailed process for recruitment of these volunteers. Senior staff were allocated responsibility for ensuring that new staff/co-workers were supervised and familiar with the needs of the residents. New staff were briefed in fire safety procedures and there was a detailed induction programme which included supernumery time for staff.

However, the actions arising from the previous inspection had not been resolved in that no agreement regarding the roles and responsibilities of volunteers had been set out in writing. Recruitment processes were not robust with inadequate references, no verification of information and unexplained gaps in the information provided.

Communication and monitoring systems between staff and management were evident. A management meeting takes place each Monday and the records seen indicate that resident care was the priority for the agenda. A system of co-worker meetings was also implemented.

The consistent system for the formal practice supervision of staff had not commenced. She outlined her intention to address this.

Staff were observed to be patient fully engaged with and very supportive of the
residents and were aware of the statutory requirements and standards in relation to the delivery of care. Copies of relevant guidance was available at the centre.

**Judgment:**
Non Compliant - Moderate

**Outcome 18: Records and documentation**

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Theme:**
Use of Information

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Inspectors found that the records required by regulations in relation to residents, including assessments, personal plans and medical reviews were not entirely complete. They did not consistently detail the care provided or required by the residents. Some records were not adequately signed, some were not dated and it was difficult to ascertain the role of those attending meetings on behalf of residents. Records of personal belongings were maintained.

Records required by Schedule 2 in relation to staff were found to be incomplete.

A number of policies required amendment. This included the risk management policy and the policy on behaviours that challenge. Documents such as the residents guide and directory of residents were available and up to date. The inspector saw that insurance was current. Reports of other statutory bodies were also available. A visitor's log had commenced prior to the inspection.

**Judgment:**
Non Compliant - Moderate
Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Camphill Communities of Ireland</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003610</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>16 September 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>19 October 2015</td>
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Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that a comprehensive multidisciplinary assessment was not carried out consistently prior to the admission of residents.

1. Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that the annual reviews were multidisciplinary.

2. **Action Required:**
Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

**Please state the actions you have taken or are planning to take:**
A checklist of required and invited multidisciplinary professional will be drawn up and in future will be completed part to the annual review to encourage and enable allied health professionals to attend review.

House co-ordinators will be informed that any new actions need to involve a time frame for completion and person responsible on 19/10/15.

The review forms will be updated to include sections for any new actions, time frame for completion and who will be responsible by 30/11/15.

The house co-ordinators will be informed that the PIC needs to be involved in the planning for resident reviews to ensure they are multidisciplinary. To be completed by 26/11/2015.

The appointment of a registered nurse as PIC will strengthen the multidisciplinary input.

The review form will be updated to include a section for interventions by allied disciplines.

**Proposed Timescale:** 30/11/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that the personal plan is the subject of a review if there is a change in needs or circumstances and this review assesses the effectiveness of the plan.

3. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
All residents will receive an annual review of their personal plan, quarterly monitoring review and other such reviews as change of circumstances require. The guidance to staff will be updated to ensure these requirements are clear. To be completed by 30/11/15

The review form will be reviewed and updated to ensure it clearly assesses the effectiveness of the plan. To be completed by 30/11/15.

The new review form will also include sections that demonstrate that goals are being reviewed, whether or not interventions are being implemented, whether they have been effective and who is responsible for what actions within a time frame. To be completed by 30/11/15.

A programme of training for all staff engaged in the development and review of personal plans will be carried out. The training will pay particular attention to ensuring multi-disciplinary input, addressing health care and other needs identified in the comprehensive assessment of need, goal setting, setting timescales, allocating responsibility, assessing effectiveness and reviewing in light of changing circumstances and new developments. To be completed by 31/12/15

The community are employing a Deputy PIC who will have increased oversight into the social care needs of the residents. To be completed by 07/12/15.

The deputy PIC/PIC will work closely with the house co-ordinators to ensure that reviews occur as required and in line with policy. To be completed by 01/01/2016

Proposed Timescale: 20/01/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that following a review of the personal plan records will indicate;
(a) any proposed changes to the personal plan;
(b) the rationale for any such proposed changes; and
(c) the names of those responsible for pursuing objectives in the plan within agreed
time-scales.

4. **Action Required:**
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of
each personal plan review are recorded and include any proposed changes to the
personal plan; the rationale for any such proposed changes; and the names of those
responsible for pursuing objectives in the plan within agreed timescales.

**Please state the actions you have taken or are planning to take:**
The review form will be updated to reflect any changes required to the personal plans
and the rationale for the proposed changes and who is responsible for said changes and
in what timeframe. To be completed by 30/11/15.

**Proposed Timescale:** 30/11/2015
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
To ensure that the personal plan is amended in accordance with any changes recommended following a review.

5. **Action Required:**
Under Regulation 05 (8) you are required to: Ensure that each personal plan is
amended in accordance with any changes recommended following a review.

**Please state the actions you have taken or are planning to take:**
The PIC will introduce a monitoring system for personal plan reviews which will include
target timescale for personal plan updates following the review. The PIC /deputy PIC
will take responsible for signing off the completed personal plans

**Proposed Timescale:** 19/11/2015

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**Outcome 06: Safe and suitable premises**
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Continuously upgrade and maintain the premises and ensure it is suitable in design an
layout to meet the needs of the residents.

6. **Action Required:**
Under Regulation 17 (1) (a) you are required to: Provide premises which are designed
and laid out to meet the aims and objectives of the service and the number and needs
Please state the actions you have taken or are planning to take:
All residents accessing stairs will be risk assessed for the safe use of same – At least yearly and when needs change. To be completed 1/12/2015.

An ongoing repair and upgrade schedule is being implemented. We will follow the schedule as per timeframes outlined in the schedule. Effective immediate.

We will introduce a schedule for the upgrade of furnishings to ensure these are kept to a good standard. To be completed 1/12/2015

Proposed Timescale: 01/12/2015

Outcome 07: Health and Safety and Risk Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the risk management policy, details hazard identification and assessment of risks throughout the designated centre and that this is implemented in practice on a continuous basis.
This should include but not be limited to:
open fires
access to chemicals
safe use of equipment for residents
Safe use of the stairs by resident.

7. Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
The Risk Management Policy will be updated to include hazard identification and the risk assessments. To be completed 30/11/15.

The risk management framework will be reviewed at least twice yearly to ensure the implementation of same.

All files will include an updated photo of the residents. To be completed 15/12/15.

Proposed Timescale: 31/05/2016
**Theme: Effective Services**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
To take adequate precautions in the event of risk of healthcare related infections.

**8. Action Required:**
Under Regulation 27 you are required to: 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.

**Please state the actions you have taken or are planning to take:**
Hand sanitizers will be made available to all houses and specifically placed where the risk of infection is high. To be completed 31/12/15.

**Proposed Timescale: 31/12/2015**

**Theme: Effective Services**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
To take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.

**9. Action Required:**
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

**Please state the actions you have taken or are planning to take:**
Priority fire doors to be installed. To be completed 29/02/16.

All fire exit doors will have either a key in a break glass unit adjacent to the door or a yale lock in place. To be completed 31/10/15.

**Proposed Timescale: 29/02/2016**

**Theme: Effective Services**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
To make adequate arrangements for detecting, containing and extinguishing fires.

**10. Action Required:**
Under Regulation 28 (3) (a) you are required to: Make adequate arrangements for
detecting, containing and extinguishing fires.

Please state the actions you have taken or are planning to take:
Currently 94% of employees/co-workers are trained in fire safety awareness. All new employees/co-workers will continue to be inducted into fire safety by house coordinators.

Certificated training for fire safety awareness will occur four times a year. Effective immediate.

A schedule of all obligatory training required by staff and when completed will be maintained by the PIC

Proposed Timescale: 31/10/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure means of escape were adequate including servicing of emergency lighting.

11. Action Required:
Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:
A review of the fire evacuation plans of all residents will be undertaken by each House Co-ordinator to ensure these meet the needs of resident in the event of a fire evacuation. To be completed 15/11/15.
A series of fire drills will be undertaken following the reviews To be completed 30/11/15.
and any learning will be incorporated into revised evacuation plans. To be completed 15/12/15.

Emergency lighting is serviced regularly and the PIC will ensure records of same are maintained and available. To be completed 30/10/15

Proposed Timescale: 15/12/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To make satisfactory arrangements for the evacuation of residents taking their dependency levels and the premise into account.

12. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**

All PEEPs will be reviewed and updated. To be completed 30/11/15.

Any evacuation barriers found will be addressed to ensure the safe evacuation of residents. 15/12/15.

**Proposed Timescale:** 31/12/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To provide on-going fire safety training for staff.

**13. Action Required:**

Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

**Please state the actions you have taken or are planning to take:**

Fire safety training has been implanted for 94% of employees and co-workers.

Fire safety training will be carried out 4 times a year.

Fire awareness training for new employees/co-workers induction will be reviewed and updated. To be completed 31/12/15.

The daily fire checks will be consistently documented. The fire safety officer will monitor compliance. To be completed 20/11/15.

All outcomes from fire drills to be reviewed and discussed with the PIC. Effective immediate.

The fire marshal information will be reviewed and updated to ensure consistently across all areas. To be completed 31/10/15

**Proposed Timescale:** 20/11/2015

**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

To put in place safe effective systems as outlined by the fire safety risk assessment for the prevention and management of fire in the premises.
14. **Action Required:**
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

**Please state the actions you have taken or are planning to take:**
A schedule of works will be carried out to ensure compliance with fire safety certification: To be completed by 29/02/16.

**Proposed Timescale:** 29/02/2016

<table>
<thead>
<tr>
<th>Outcome 08: Safeguarding and Safety</th>
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<td><strong>Theme:</strong> Safe Services</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failure to take sufficient action to protect all residents from abuse.

15. **Action Required:**
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

**Please state the actions you have taken or are planning to take:**
All employee/co-worker documents will be audited to ensure gaps in documentation is obtained. To be completed 31/12/15.

All new employee/co-workers employed/joining the community will go through rigorous recruitment process in line with HIQA requirements by the PIC and admissions clerk prior to their start date. Effective immediate.

Alternative means to the bank acting as agent for several residents will be sought. To be completed 31/01/16.

Bed rail protector guards will be utilised instead of cushion. To be completed 13/11/15.

The bed rails will be included in the risk assessment to include regularly checking of safety and condition. To be completed 31/12/15.

**Proposed Timescale:** 31/01/2016

| Theme: Safe Services |

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To adequately investigate and report allegations of abuse.

16. **Action Required:**
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The PIC, Deputy PIC and safeguarding officers will receive training in systems analysis and apply this method to incidents and safeguarding issues. To be completed 31/12/15.

The HSE safeguarding policy will be followed in conjunction with the national CCoI policy. Effective immediate.

Proposed Timescale: 31/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that staff have adequate training in the protection of vulnerable adults.

17. Action Required:
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Please state the actions you have taken or are planning to take:
Safeguarding officers, PIC, Deputy PIC will receive further training and ongoing training on safeguarding. To be completed 31/12/15.

All employees/co-workers will receive ongoing training on safeguarding and a schedule of the training programme will be maintained by the PIC. To be completed 29/02/16.

Proposed Timescale: 29/02/2016

Outcome 11. Healthcare Needs

Theme: Health and Development

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To consistently provide timely access to health care and implement health care plans where required.

18. Action Required:
Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

Please state the actions you have taken or are planning to take:
A review of the health care information and recording of same will be undertaken as part of the personal plan training referred to in Outcome 5. To be completed by 31/12/15

The community is currently recruiting for a deputy PIC/Social Care Co-ordinator. Their main role will be to oversee the social care provided to residents in conjunction with the house co-ordinators and PIC.

Co-ordination of consistent and timely access to GPs, documentation of visits and implementation of protocols to support specific healthcare needs will occur by the deputy PIC/Social Care Co-ordinator. A joint meeting of house co-ordinators, PIC and the local GP will take place to discuss communication and recording of information. To be completed by 30/11/15 All employees/co-workers will be familiar with the personal care plans and specific protocols. To be completed 30/11/15.

Proposed Timescale: 31/12/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Failure to provide evidence of compliance with the planning authority.

19. Action Required:
Under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013. you are required to:
Provide all documentation prescribed under Regulation 5 of the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
The engineer is in the process of obtaining relevant documentation regarding compliance with the planning authority. To be completed 29/02/16.

Proposed Timescale: 29/02/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Governance structures were not effective and roles and responsibilities were not defined to ensure the effective and safe delivery of care.

20. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined
management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

**Please state the actions you have taken or are planning to take:**
Roles and responsibilities for people participating in management will be reviewed and updated. To be completed 25/01/2016.

A line management supervision schedule is currently in place where governance structures, and roles and responsibilities are discussed to ensure the effective and safe deliver of care. Effective immediate.

**Proposed Timescale:** 25/01/2016

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To provide effective overview of care practices and staff training to ensure all staff effectively carry out the duties.

**21. Action Required:**
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

**Please state the actions you have taken or are planning to take:**
The recruitment of a deputy PIC to/Social Care Co-ordinator will assist the PIC to provide greater overview of care practices. To be completed 1/12/15.

A training schedule for staff will be developed and will include specific training for staff to carry out their duties effectively. To be completed by 29/01/2016

**Proposed Timescale:** 29/01/2016

**Outcome 16: Use of Resources**

**Theme:** Use of Resources

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that expenditure required for the implementation of the fire safety management plan was available

**22. Action Required:**
Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is
resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

**Please state the actions you have taken or are planning to take:**
A fire safety management plan has been drawn up. Increased funding has been applied for from the HSE, regionally and nationally. This is an ongoing process, the adequateness of funding to meet the assessed needs of residents will be kept under review to ensure both a safe and effective delivery of care and support for each resident can be met in line with the Statement of Purpose of the designated centre. Effective immediate.
The annual budget review to the centre will consider the need for upgrade in light of the fire safety management plan. To be completed 15/12/2016

**Proposed Timescale:** 15/12/2016

<table>
<thead>
<tr>
<th><strong>Outcome 17: Workforce</strong></th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Responsive Workforce</td>
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</table>

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
To have an accurate and maintained staff roster.

<table>
<thead>
<tr>
<th><strong>23. Action Required:</strong></th>
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<tbody>
<tr>
<td>Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.</td>
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</tbody>
</table>

**Please state the actions you have taken or are planning to take:**
Implementation of an accurate and maintained staff roster will occur which also includes the volunteer co-workers. To be completed 31/12/15

**Proposed Timescale:** 31/12/2015

| **Theme:** Responsive Workforce |

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
To ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.

<table>
<thead>
<tr>
<th><strong>24. Action Required:</strong></th>
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<tbody>
<tr>
<td>Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.</td>
</tr>
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</table>

**Please state the actions you have taken or are planning to take:**
All employed staff related documents specific to Schedule 2 are obtained.
An audit of all co-worker files will occur to determine what necessary documents are absent which will then be sought. To be completed 29/01/2016.
The PIC will be directly involved with new staff and co-workers joining the community to ensure all necessary documents are sought prior to arriving in the community. Effective immediate.

An agreement of the roles and responsibilities of volunteers will be developed and implemented. To be completed 31/12/15.

**Proposed Timescale:** 29/01/2016

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Mandatory training was not updated or proved to staff with the required timescale.

**25. Action Required:**
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
A new training record has been implemented which accurately reflects training dates. Effective immediate.

A new training schedule will be implemented to ensure staff have access to the required training, including refresher courses. To be completed 31/12/15.

**Proposed Timescale:** 31/12/2015

**Theme:** Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
To ensure that volunteers with the designated centre have their roles and responsibilities set out in writing.

**26. Action Required:**
Under Regulation 30 (c) you are required to: Ensure volunteers working in the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (No. 47 of 2012).

Please state the actions you have taken or are planning to take:
All volunteer co-workers have currently provided a vetting disclosure in accordance with the National Vetting Bureau Act. Effective immediate.

**Proposed Timescale:** 31/10/2015
### Outcome 18: Records and documentation

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
All of the required policies were not complete and implemented.

#### 27. Action Required:
Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
The risk management policy will be reviewed and updated and include all risk assessments. To be completed 31/12/15.

The policy on positive behavioural support and the use of restraint will be reviewed and updated. To be completed 29/02/16.

**Proposed Timescale:** 29/02/2016

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**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
To ensure that the records required by regulation 21 (1) in relation to staff and residents were maintained in an accurate and complete manner.

#### 28. Action Required:
Under Regulation 21 (1) (a) you are required to: Maintain, and make available for inspection by the chief inspector, records of the information and documents in relation to staff specified in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

**Please state the actions you have taken or are planning to take:**
All documents relating to Schedule 2 for staff are obtained.

All documents relating to Schedule 2 for volunteers will be obtained. To be completed 29/01/2016

**Proposed Timescale:** 29/01/2016

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**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
To ensure that the records required by regulation 21 (1) in relation to residents were maintained in an accurate and complete manner.

29. **Action Required:**
Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

**Please state the actions you have taken or are planning to take:**
All documents relating to Schedule 3 for residents will be obtained. To be completed 31/12/2015.

The deputy PIC/Social Care Co-ordinator will monitor the personal care plans and resident files to ensure consistent detail of the care provided or required by the residents. To be completed 31/12/15.

**Proposed Timescale: 31/12/2015**