Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003610
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Lead inspector:	Noelene Dowling
Support inspector(s):	Conor Dennehy
Type of inspection	Unannounced
Number of residents on the date of inspection:	27
Number of vacancies on the date of inspection:	1

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 monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
08 March 2016 09:00	08 March 2016 19:00

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

The purpose of this inspection was to follow up on the actions required from the registration inspection of the centre which took place in September 2015. At that inspection here were 29 actions identified including major non compliances in safeguarding, health and safety including fire safety, and moderate non compliances in health and social care governance and management, staffing and documentation.

Following that inspection the Authority, in line with its procedures, held a meeting with the provider to ensure the concerns of the Authority were clearly understood and seek reassurances that the actions would be addressed.

This was the third inspection of this centre which provides long term residential services to people with intellectual disability, people on the autism spectrum and physical and sensory disabilities. A service is provided to 29 residents in eight units on the campus. One unit which had been included at the original registration inspection was removed from the application by the provider.

This inspection was unannounced. On the day of the inspection there were 27 residents living in the centre. Inspectors met with residents and staff and observed practices.

Inspectors reviewed documentation including policies and procedures, personnel files, health and safety documentation, resident's records and personal plans.

The actions required following the previous inspection which took place in September 2015 were reviewed. A total of 29 actions were required. Of this number 12 were resolved or there was evidence of good progress in doing so. Three were partially resolved. These actions included personal planning and the holding of multidisciplinary reviews, assessment of need for residents and access to health care.

There were improvements evident in the recruitment procedures and in the number and skill mix of staff. There was an increase in the number of trained staff employed to augment the volunteer system which was the traditional staffing arrangement. Additional staff had been sourced as needed to support residents at times of illness of residents who required one to one support.

There was an improvement evident in the local governance structures with the appointment of a full time deputy person in charge. The person in charge had undertaken significant work in the development of personal planning framework for residents, and improved access to healthcare. Supervision systems for staff had commenced.

Fifteen actions were not addressed.

Significant improvements were still required in the following areas:
- safeguarding,
- fire safety systems,
- risk management strategies,
- and mandatory training for staff in fire safety and safeguarding.

Additional actions were also required in providing access to clinical support for residents with challenging behaviours, notifications to the Authority of significant events; and the overview of the management of residents´ finances.

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

Findings:
The previous inspection found that a comprehensive multidisciplinary assessment was not carried out consistently prior to the admission of residents. Annual reviews were not multidisciplinary or carried out as changes in need or circumstances occurred, they did not identify time frames and named persons responsible for implementation of the personal plans.

At this inspection the findings showed improvements in all of these arrangements and evidence of review of the outcomes for the residents.

A proposed admission was being considered and the inspector found that all relevant information was sourced and meetings were held with the resident, representatives and relevant professionals to ensure the provider could meet the needs of the residents.

A revised system for review, and personal planning documentation had been implemented prior to the inspection. Some of the documentation therefore was not complete but the inspector was satisfied that the systems were in progress.

Of the five residents records reviewed by the inspectors, there was evidence of multidisciplinary assessment of need in a range of health and psychosocial needs. There were multidisciplinary assessments sourced including speech and language, physiotherapy, psychiatry, opticians and audiology. These interventions were included in the reviews which had taken place. Details in the documentation indicated that resident's wishes, preferences and abilities were very well known by staff and each file held a pen picture which was very person-centred.

Annual reviews had taken place with revised documentation in place to include the outcome of the review, assess the impact of the plans being made and the interventions of allied services involved with the residents. Families and or representatives were involved in these processes.

There was a revised personal planning document in place which when fully implemented will ensure that resident's needs are identified, and the outcomes of the process will be evident. There were timeframes and named persons responsible for ensuring that this occurred. A process of staff training in implementing and managing the revised systems had also commenced.

Inspectors saw and residents confirmed that they continued to enjoy meaningful activities and choice in their daily lives.

Judgment:
Compliant

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

Findings:
The previous inspection found that a system for the continuous upgrade and maintenance of the centre was required to ensure it was suitable in design and layout to meet the needs of the residents.

Bathrooms which had been in the process of renovation had been completed. However, one bathroom on the second floor of one house was not suitable for use by the resident concerned. It was non-assisted, with a standard bath and with no safety features or hand rails. While other parts of the premises meets the needs of the resident group this will need to be monitored as their dependency levels change. A number of toilets and showers required replacing.

The inspectors were informed by the person in charge that a systematic replacement of furnishings including beds, wardrobes and linens was being undertaken and would be replaced where needed. Overall, the premises was homely in style and comfortable.

Judgment:
Non Compliant - Moderate

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:
The previous inspection found that the risk management policy, assessment of risk and implementation of risk management strategies were not satisfactory. Arrangements for the evacuation of residents taking their dependency levels and the premises into account were not robust. In addition, significant works with regard to fire safety including the installation of fire doors, suitable alarm systems and emergency lighting systems had not been completed, despite the provider undertaking to address these issues.

On this inspection, inspectors found that these actions had still not been satisfactorily addressed even though the timeframes submitted to Authority by the provider had expired.

This centre was first inspected in May 2014 where inspectors present saw a fire safety assessment and risk report for the designated centre. This highlighted a number of works that needed to be carried out to ensure the safety of residents in the event of a fire such as the installation of fire doors and compartmentalisation. Some of the risks identified were red rated risks and were required to be actioned within a three month period.

Following on from the May 2014 inspection an action plan was submitted to the Authority stating that such works would be completed by September 2015. The centre was again inspected in September 2015 and it was found that such works had not commenced. Again an action plan was submitted to the Authority stating that such works would be completed by February 2016. An internal safety audit of the designated centre, carried out by an external consultant in October 2015, also highlighted the need for such works to be carried out.

As a result of the lack of action by the provider following the second inspection of the designated centre the concerns relating to fire safety were highlighted to the county fire officer who visited the centre in December 2015. As a result the Fire authority carried out a review of the centre on 8 December 2015. A list of the priority works was again agreed. These were to be carried out within a four month time frame.

At the current inspection by the Authority it was found that, aside from some works relating to the insertion of thumb locks, none of the priority works had commenced.

Inspectors were informed that half the funding for the remaining works had been secured while verbal assurances had been received from the provider nominee regarding the remainder. However, satisfactory documentary evidence of this was not available on the day of inspection and there was no timeline given for when these works where due to be completed or even begin. This situation was wholly unsatisfactory.

Inspectors reviewed staff training records and found that training in relation to fire safety had been provided to most of the workforce. It was noted however, that four members of the workforce were not listed as having undergone any fire training. Outcome 17. Fire drills were taking place at regular intervals at varying times. Staff and volunteers spoken to were aware of the needs of residents in the event that an evacuation was necessary.

A selection of personal evacuation plans were seen by inspectors and although some had been updated to reflect recent evacuation drills it was noted that some plans did not take account of, or again were contradictory to residents' current needs for support with mobility.

Internal fire safety checks were being carried out but these were not consistent. Maintenance records were seen for the fire alarm system and fire extinguishers but such records for the emergency lighting were only available for three of the houses within the designate centre.

A safety statement, emergency plan and risk register were in place. A risk management policy had been amended in compliance with an action from the previous inspection. While the policy framework was very detailed practices and review of risks were not satisfactory.

Risk assessments were undertaken for residents with specific reference to their individual needs. However, a number of these did not take account of resident's changing needs to ensure appropriate control measures were put in place. For example one resident, whose mobility levels were decreasing, continued to reside in an upstairs location and use a bathroom which was not suited to their changing needs. There were a number of risk assessments in relation to this and they were contradictory.

Inspectors reviewed a log of accidents and incidents within the designated centre. Such incidents had recently begun to be reviewed by the deputy Person in Charge which helped ensure a greater overview. A summary of such events was maintained. However, it was noted that some of the incident reports read contained limited information and it was not always clear what action had been taken, if any following the incident. For example, a fall by a resident in an unsuitable bathroom had not resulted in any changes or additions to make the bathroom safer. Systems for learning and review therefore still required improvements.

Infection control measures as required been implemented.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
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.

Theme:
Safe Services

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

Findings:
The previous inspection found that the provider had failed to take sufficient action to protect all residents from abuse, to implement safeguarding plans when issues arose , to adequately screen or investigate any issues which arose and to provide training for staff in the protection of vulnerable adults. Historical allegations had not been satisfactorily addressed and the policy on the use of behaviour support was not satisfactory.

On this inspection it was found that Improvements were still required in these areas. The required training for staff had not taken place. The person in charge and the designated officer had not received the training required to implement the policy in line with that of the Health Service Executive HSE). They had however, attended a half day briefing on this.

A notification of alleged abuse received by the Authority in December 2015 had been investigated and reported according to the policy, actions were taken to ensure the safety of the residents and remove the alleged abuser from any access to residents. However, inspectors were very concerned at the process used internally when information came to light which suggested further inappropriate conduct on behalf of a staff member.

There were no records of either the information, or of the actions taken in response to this. The details in the final outcome report differed significantly to that given to the inspectors during the inspection. The person in charge concurred that she had also been given different information regarding this. The actions taken to manage this misconduct in fact consisted of one brief informal talk.

Therefore, inspectors were not assured that robust systems were in place or that staff had the knowledge and skills to recognise potentially abusive situations. Inspectors acknowledge that there were no risks to residents identified at this time and the alleged abuser no longer works at the centre.

From a review of documentation including an investigation report, documents in the centre and from speaking with staff, inspectors were not satisfied that processes were adequately implemented, overseen or the potential risk recognised.

The systems for protecting residents from financial abuse were not entirely satisfactory. A number of residents required full or partial support with the management of their finances. There were consent forms signed either by the resident or their representatives in regard to this. There were detailed statements available to the residents and bank cards were held securely in the units. Access to these was limited. Inspectors found that all expenditure including fee payments and other expenses incurred were detailed and carefully receipted. A recent system of auditing the receipts and monies in the units had commenced.

However, while inspectors found no evidence that any untoward actions had taken place there was no safeguarding system to ensure withdrawals were monitored or that significant amounts of money could not be withdrawn without agreement and oversight.

The policy on the management of challenging behaviours had not been updated to guide practice although the policy on the management of restrictive practices was suitable. A number of residents had behaviour support plans in place which were detailed and distracted supports for the residents. A number of strategies including facilitating residents to live in single occupancy arrangements had been implemented to good effect. Supportive routines were also in place for the residents and staff were familiar with them. There was evidence that a resident who lives alone due to reactive behaviours was making good progress in being slowly reintegrated into the community.

However, while there was evidence of frequent and supportive psychiatric intervention there was a significant deficit found in clinical behavioural support available to the residents and the staff. One resident had recently accessed private behaviour support intervention and an analysis of behaviours and patterns had commenced. However, this support was not available to other residents whose needs and behaviours indicated this was required.

Some of the incident records seen and behaviours described were of a significantly serious and complex nature. It was apparent that despite the obvious good will and support of the staff further clinical expertise was necessary if the provider was to meet the of the residents this respect.

A number of restrictive practices were in place these included door alarms, and an additional alerting devise to alert staff as to when a left the bedroom. These were primarily to ensure the safety of other residents. Additional staffing had been provided overnight and during the day to augment this.

These actions were also impacted on by the lack of available behaviour psychological supports and guidance for staff.

There was a protocol in place for the use of medication where this was prescribed for anxiety or behaviour. Inspectors found that this was not used inappropriately and it was reviewed regularly by the prescribing psychiatrist.

Judgment:
Non Compliant - Major

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:
During the course of inspections inspectors were informed two allegation of misconduct by staff members. These had not been notified to the Chief Inspector as required.

Judgment:
Non Compliant - Major

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:
The previous inspection had found that timely access to healthcare and healthcare plans where required was not fully complied with. This action had been resolved

Residents continued to have their healthcare needs, including nutritional needs, met and residents had access to appropriate medical and allied healthcare services. There was evidence of regular access to GP services and on this inspection there were documentary records of these visits and the outcomes available. There was evidence that staff responded promptly to symptoms of illness. Inspectors saw a protocol implemented by the person in charge in regard to the issuing of pain management medication which had been a concern at the previous inspection.

In line with their needs inspectors were satisfied that residents had ongoing access to other 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 where this was required. Staff had training in the administration of this.

A number of residents required their meals or fluids in modified or altered form which had been prescribed by the speech and language therapist. The instructions were detailed and easily visible for staff that were very familiar with them. Where required fluid monitoring systems these were implemented and monitored.

Increased staffing support was provided at times of illness which was evident at this inspection. Wound prevention protocols were implemented and skin integrity monitored and reported on consistently. Records of regular turning of the resident was maintained. A hoist had recently been sourced and staff were undergoing training in the safe use of this equipment. However, a resident assessed as at very high risk of pressure areas did not have a pressure relieving mattress. This was discussed with the person in charge who agreed to address this.

There was no care plan to guide the care for a resident with a catheter, and a personal plan had not been revised in response to a significant change in a resident's health status. However, from a review of in the residents' daily, nightly and other records and from speaking with staff inspectors were satisfied that there was sufficient evidence to show that the required care was being delivered.

Inspectors reviewed the records in relation to a resident who had passed away at the centre. A revised care plan had been implemented; there was evidence of medical review advice from the community care services and spiritual and personal support for the resident. Pain and symptom management interventions were implemented. Additional staffing had been provided. It had been the wishes of the resident and family that the resident pass away in what had been her home and this had been facilitated.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing, administration and disposal of medicines.

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.

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 and this had been completed.

However, in one of the units inspectors noted that items other then medication were stored in the cabinet and when staff were accessing these items the content of the cabinet was at risk.

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. There were documentary systems for this procedure.

Training had been provided to staff/co-workers on medication management. There was currently no follow up assessment of competency included in this training. Inspectors were informed that this was included in the training planned for 2016. Inspectors saw that homeopathic medicines were used. These were agreed for compatibility by the residents GP.

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

Findings:
The previous inspection found that governance structures were not effective and roles and responsibilities were not defined to ensure the effective and safe delivery of care. There was no effective overview of care practices and staff training to ensure all staff effectively carried out their duties.

There were improvements found on this inspection in the local management structures. Since December 2015 the provider had employed a fulltime deputy person in charge. This person was suitably qualified in social care and had suitable experience in the organisation and with persons with a disability.

The local management roles and responsibilities were clearly defined. The person in charge who had been very new to the organisation and the jurisdiction at the previous inspection was suitably qualified in nursing and had experience in mental health services. She was full time in post and was seen to be fully involved in the day to day and strategic operations of the centre. While residents did not require fulltime nursing her overview of their health care needs and personal planning has been of benefit.

Staff expressed their satisfaction with the revised structures and systems and said that the changes being made were constructive and of benefit to the residents. There are weekly local management meetings held to ensure consistency and development of practices in the centre. The impact of these revised structures could be seen in the overview of care practices and care delivery to the residents.

As required by the regulations the provider had undertaken two unannounced visits to the centre in 2015 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 visit for 2016 is due in Spring 2016. Avenues including the residents meetings and day-to-day meetings were providing avenues for consultation with the

residents.

However, the action in relation to the fire safety works, in particular those required as priority items for completion within a four month period and the safeguarding findings and deficits in staff training in crucial areas indicate that the provider has not demonstrated a commitment to achieving compliance, and acting to ensure that the service is safe.

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

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.

Theme:
Responsive Workforce

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

Findings:
The previous inspection found that mandatory training for staff in crucial areas was not provided, recruitment procedures were not robust, there was no accurate staff roster, and the volunteers did not have their roles and responsibilities defined.
All of these had been partially but not fully addressed.

The designated centre's workforce consisted of a combination of short term volunteers, long term volunteers and paid members of staff in accordance with the provider's model of care. Since the previous inspection additional paid staff had again been employed by the centre. These staff had come from a social care background and this was found to be a positive development. There was a sufficient workforce number to support residents and inspectors observed warm interactions between residents and the workforce throughout inspection.

There was an improvement found in the recruitment information sourced for staff and volunteers. An audit of staff files had been conducted which was seen by inspectors. Omissions and discrepancies were identified and followed up on. Inspectors reviewed a sample of staff files and found the majority of the required information such as Garda

vetting and written references were in place. Gaps in information were also identified by the person in charge.

The provision of training remained an area in need of improvement. As highlighted under Outcome 8 a significant proportion of the workforce had still not received sufficient safeguarding training. Inspectors reviewed training records and found that some of the workforce continued to require training in areas such as manual handling and the management of aggression and violence. Inspectors did see a projected schedule of training up until June 2016 covering these topics however.

A formal system of supervision for staff and volunteers had recently commenced, however this had not been fully implemented at the time of inspection. The Person in Charge outlined plans to hold monthly supervision meetings with staff and record these in staff files. The Person in Charge said that such meetings were not yet happening at regular intervals for all staff.

While reviewing staff files records of supervision were found for some staff but these varied in quality. For example one such record consisted of a two sentence handwritten note which contained limited information.

The deputy Person in Charge had also recently commenced supervision meetings with volunteers on a house per house basis. This had only begun in the weeks before inspection and some houses within the designated centre, where volunteers resided, had not yet had such meetings.

The findings regarding the safeguarding noted in Outcome 7 safeguarding indicate that this more robust system is required.

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

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003610
Date of Inspection:	08 March 2016
Date of response:	31 March 2016

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 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The design of some bathrooms did not meet the needs of some of the residents.

1. 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 of residents.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

Please state the actions you have taken or are planning to take:
Planned upgrades in toilets and showers will be completed as scheduled. The specific resident's bathroom will be improved to ensure it has hand rails and safety features suitable for the resident concerned. This resident will be referred to an Occupational Therapist to complete functional assessment around mobility and need.

Proposed Timescale: 20/05/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for learning and review from accidents or untoward events were not robust.

2. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The PIC will oversee the Deputy PIC carrying out quarterly analysis and any outcomes of the incident & accident register including the challenging behaviour incident register will be carried out.

Escalation of learning from quarterly analysis will be shared locally and nationally.

The Deputy PIC will include more information on the accident and incident register.

Proposed Timescale: 30/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Risks within the designated centre were not being adequately assessed and managed.

3. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
Two residents risk assessments and personal evacuation plans have been reviewed and updated.

A review of all residents risk assessments will be carried out to ensure they are up to date.

Proposed Timescale: 28/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Necessary fireworks identified on previous inspections had not been completed so as to ensure fire management systems were satisfactory.

The fire safety works agreed with the local authority had not commenced.

Deficits included but were not exclusive to:
• suitable fire alarms
• emergency lighting
• containment systems.

4. 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:
The tendered builders and engineers are builders are carrying out new costings and timeframes for the priority fire upgrades.

An outline of the timeframe for priority works to be completed will be forwarded to the authority once complete.

The PIC will provide monthly updates to the authority.

An anticipated start date is mid-April 2016.

Proposed Timescale: 30/08/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal evacuation plans were not reflective of residents' needs.

5. 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 are up to date.

The PIC will work closely with the house co-ordinators to discuss and ensure any changes to the residents needs are adequately and accurately reflected in their personal evacuation plans.

Proposed Timescale: 05/04/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A number of staff had not received fire safety and management training.

6. 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:
The four employees/co-workers will receive fire safety and management training on the 01/04/2016.

The community now have an employee who is trained in providing fire training and will be able to provide this training on a more regular basis.

Fire Marshal training occurred on the 22/03/2016. Induction training of fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and arrangements for the evacuation of residents occurs within the first two weeks of joining the community – The PIC will ensure record keeping of this is more accurate and completed in a timely manner.

Training for firefighting equipment, fire control techniques is completed during the fire training course that will occur on a quarterly basis.

First aid training will also occur on a quarterly basis.

An updated schedule of fire safety and management training, first aid and fire marshal training will be forwarded to the authority.

Proposed Timescale: 01/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failure to source adequate clinical support and intervention to guide staff and support residents with behaviours that challenge.

7. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
PIC will procure private behavioural support to guide staff and support residents with behaviours that challenge.

The Behavioural Support & Use of Restraint policy has been updated to reflect national policy changes.

Proposed Timescale: 01/05/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was a failure to take sufficient action to protect residents from abuse.

8. 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:
The deputy PIC has attended the HSE two day safeguarding training.

The PIC is attending the HSE two day safeguarding training on the 7-8th/04/2016. Further safeguarding training will be provided to the house co-ordinators on the 08/04/2016

Further safeguarding training for Co-workers/employees is scheduled for the 16/03/2016, 30/03/2016, 11/05/2016 & 31/05/2016.

The Wexford HSE Vulnerable Adults Team will provide train the trainer safeguarding training to the Deputy PIC/Designator Officer and other members to the community. PIC and Deputy PIC will report all allegations of abuse and suspected allegations of abuse and take appropriate action to protect residents from abuse.

Camphill Communities of Ireland National Case Management Team will be launching a campaign of safeguarding awareness with posters and workshops.

A safeguarding audit is being developed to audit the compliance of safeguarding framework and policy following safeguarding training from members of the Community, on quarterly basis.

The HSE Wexford Vulnerable Adults team will be reviewing the process and outcomes of two allegations of abuse that have occurred with the Community and the National Case Management Team.

The National Case Management Team will arrange for an independent Camphill Community review of the allegation of abuse investigation.

Proposed Timescale: 05/04/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a failure to identify adequately investigate any allegation or suspicion of abuse.

9. 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 deputy PIC has attended the HSE two day safeguarding training.

The PIC is attending the HSE two day safeguarding training on the 7-8th/04/2016. Further safeguarding training will be provided to the house co-ordinators on the 08/04/2016

Further safeguarding training for Co-workers/employees is scheduled for the 16/03/2016, 20/03/2016, 11/05/2016 & 31/05/2016.

The Deputy PIC and PIC will be better informed following the training to ensure adequate identification and investigation of any allegation or suspicion of abuse.
The Camphill Community of Ireland National Case Management Team will be carrying out a review of the investigation process into the allegation of abuse to identify any learning.

The HSE Wexford Vulnerable Adults team will be reviewing the process and outcomes of two allegations of abuse that have occurred with the Community and the National Case Management Team.

Proposed Timescale: 18/05/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Failure to ensure that staff have sufficient training in the protection of vulnerable adults and their own responsibilities in relation to this.

10. 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:
The deputy PIC has attended the HSE two day safeguarding training.

The PIC is attending the HSE two day safeguarding training on the 7-8th/04/2016. Further safeguarding training will be provided to the house co-ordinators on the 08/04/2016

Further safeguarding training for Co-workers/employees is scheduled for the 16/03/2016, 20/03/2016, 11/05/2016 & 31/05/2016.

Proposed Timescale: 31/05/2016

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of abuse had not been notified to the Chief Inspector.

11. Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
The NF06 notification has been sent to the authority on the 18/03/2016.

Proposed Timescale: 18/03/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
An allegation of misconduct by a staff member had not been notified to the Chief Inspector.

12. Action Required:
Under Regulation 31 (1) (g) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation of misconduct by the registered provider or by staff.

Please state the actions you have taken or are planning to take:
These NF07 notifications have been sent to the authority on the 22/03/2016

Proposed Timescale: 22/03/2016

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:
Evidence of compliance with the planning authority remained outstanding.

13. 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 PIC has posted copies of these to the authority on the 25/03/2016.

Proposed Timescale: 25/03/2016

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, staff training and compliance with fire safety and safeguarding requirements.

14. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to

residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
Refer to earlier actions in Outcome 07: Health & Safety Risk Management and Outcome 08: Safeguarding and Safety.

The PIC will closely monitor and oversee the care practices by receiving updates on the residents on a regular basis from the house co-ordinators.

The PIC will have greater oversight of the training requirements and ensure that these are carried out and adequately recorded and in a timely manner.

Proposed Timescale: 30/08/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The provision of mandatory training for staff in fire safety and safeguarding and challenging behaviour was not satisfactory.

15. 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:
The PIC will ensure the mandatory training in fire safety and safeguarding and challenging behaviour are procured and carried out more frequently.

A copy of the updated training schedule will be forwarded to the authority.

Proposed Timescale: 27/05/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Formal staff supervision had yet to be fully implemented.

16. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The PIC will ensure that co-workers and employees are receiving formal line management supervision on a regular basis and this is recorded.

The PIC will inform those providing supervision that the supervision record requires more detail.

Proposed Timescale: 05/04/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The supervision arrangements for volunteers had yet been fully implemented.

17. Action Required:
Under Regulation 30 (b) you are required to: Provide supervision and support for volunteers working in the designated centre.

Please state the actions you have taken or are planning to take:
The PIC will ensure that co-workers and employees are receiving supervision on a regular basis and this is recorded.

The PIC will inform those providing supervision that the supervision record requires more detail.

Proposed Timescale: 05/04/2016