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:	Camphill Community Ballytobin
Centre ID:	OSV-0003604
Centre county:	Kilkenny
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):	Gary Kiernan
Type of inspection	Unannounced
Number of residents on the date of inspection:	19
Number of vacancies on the date of inspection:	2

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 following receipt of unsolicited information. 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:
09 May 2017 09:30	09 May 2017 17:30

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

Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management

Summary of findings from this inspection

This inspection was triggered following the receipt of information of serious concern by HIQA relating to the safeguarding of vulnerable people, some of whom could not speak for themselves, and the inadequate responses of the provider to such matters. The inspection focused on the areas of Safeguarding and Governance and Management.

Following poor findings on previous inspections, particularly in relation to the provider's arrangements for safeguarding residents from the risk of abuse, the provider had been issued with a Notice of Proposal to cancel the registration of the centre in December 2016. The provider had submitted representation to the chief inspector setting out how they had addressed the areas of concern and there had been an inspection of the centre in February 2017 to verify whether these actions had been effective.

That inspection had found that while there continued to be levels of non compliance, there had been improvements since the previous inspection, but further improvements were required in a number of areas, including safeguarding and staff supervision.

When the provider was issued with a notice of proposal to cancel the registration in December 2016, the office of chief inspector had required the provider to undertake a review of all safeguarding incidents, allegations of abuse and staff misconduct.

Prior to this inspection, a number of allegations of serious physical and sexual abuse were identified by the safeguarding officer as part of the review and were notified to the chief inspector, as required by regulations. While some of the allegations were

historical, the most recent allegation dated to 2014.

Inspectors sought further information and found that the provider was unable to provide sufficient and clear evidence as to whether these allegations had been adequately investigated or reported to the relevant authorities and also found that some of the staff involved in these allegations continued to work with residents in the centre. Inspectors found that the response of the provider was inadequate, and did not ensure the safety of residents either at the time of the alleged incidents or when they were recently informed of them again as part of the current review.

Given the serious nature of the alleged incidents, inspectors informed the Gardaí and the National Safeguarding Office of the Health Service Executive in order to ensure the required reports were made. In addition, inspectors required the provider to take immediate action to ensure the safety of residents. The formal response by the provider was inadequate and did not demonstrate a satisfactory understanding of the nature of the concerns. A date for September 2017 was suggested for the removal of some of the persons concerned. In light of this response the provider was required to identify and implement specific actions that ensured the safety of residents while the issues were being properly investigated.

Inspectors found that some long term voluntary co-workers and some senior managers had been aware of the allegations but had not investigated them appropriately and had not notified the chief inspector, as required by the regulations. Inspectors found that:
- the provider, including members of the board of directors were aware of the allegations
- the provider had failed to investigate these serious allegations in an appropriate and thorough manner to ensure the safety of residents
- the provider had failed to take responsive action and follow basic safeguarding procedures
- the provider had allowed staff and voluntary co-workers against whom allegations had been made to continue to work and live with vulnerable persons without an adequate safeguarding assessment and without any additional supervision
- the provider had failed to take action when senior staff in the centre did not follow appropriate safeguarding procedures.

The purpose of this triggered inspection was to verify whether the actions that the provider said they had now taken to protect residents from the risk of abuse were being implemented, appropriately supervised and were effective in safeguarding residents. Inspectors found that the provider was continuing to fail to put arrangements in place to keep residents safe from the risk of abuse and inspectors had to require the provider to take further action.

During the inspection a senior manager and the person in charge told inspectors that some voluntary co-workers were not implementing the improved safeguarding arrangements and inspectors saw evidence of this. Inspectors also found that the provider had not given adequate support to the person in charge or taken appropriately strong action to ensure that improved safeguarding arrangements were being implemented in all of the houses in the centre.

During the inspection the provider informed inspectors that further to a review of the alleged incidents it was found that the issues were of sufficient concern to require some voluntary co-workers to be removed immediately from the centre and prevented from having access to residents until a full and proper investigation into all issues of concern had been concluded. The provider subsequently wrote to HIQA and said that it would not be possible to complete this action until September 2017. The provider also outlined plans to use agency staff alongside voluntary co-workers as a way of monitoring the implementation of safeguarding arrangements. Inspectors found that this was not an adequate safeguarding measure as the agency staff would be unfamiliar with the residents and would not have the authority or the insight into the issues that they were expected to be monitoring.

Following the inspection, the newly appointed chairperson of the board of directors spoke with inspectors, demonstrated a clear understanding of the actions that needed to be taken to keep residents safe and set out the measures that had now been implemented. She requested a two week delay in any decision about the registration status of the centre. The Health Service Executive (HSE) also informed inspectors of action they were taking to support the provider to ensure residents were being kept safe and immediate risks were being managed.

However, given the seriousness of the incidents and the repeated failures of the provider to effectively address the safeguarding of residents, HIQA issued a final Notice of Decision to cancel the registration of Camphill Community Ballytobin on 22 May 2017. In accordance with the Health Act 2017, as amended, the provider has a right to appeal the decision of the office of chief inspector to the district court within 28 days. HIQA also scheduled a further monitoring inspection shortly after the issuing of the Notice of Decision to assess whether the measures taken had addressed the immediate risks to residents and whether the time frame for cancellation of the registration needed to be escalated.

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 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):

Findings:
This inspection was a triggered inspection which focused on the safeguarding of residents from the risk of abuse. Inspectors found that the provider did not demonstrate an understanding of evidence based safeguarding practice to keep residents safe from the risk of abuse and did not demonstrate an ability to respond appropriately when safeguarding issues arose.

Following the issuing of a Notice of Proposal to cancel the registration of the centre, inspectors had required the provider to undertake a review of any allegations or incidents of abuse, and any allegations or incidents of staff misconduct. As a result of this, the chief inspector was notified of serious allegations of sexual and physical abuse, the most recent of which was dated 2014.

Inspectors sought further information and found that the provider was unable to demonstrate that appropriate action to ensure the safety of residents had been taken at the time that the allegations were made or when the provider had recently been reminded about the allegations as a result of the current review. Some staff that were involved in such allegations continued to live with residents, there had been no assessment of risk or additional measures put in place to safeguard residents pending the outcome of an appropriate investigation. The provider and managers in the centre failed to implement their current policy on the protection of vulnerable adults from abuse.

One of the allegations related to a report of sexual assault against a former voluntary co-worker by another co-worker who was a young adult at the time of the allegation. The provider's investigation found that these allegations were upheld. The matter was

not reported by the provider to the Gardaí at the time the allegations were made in 2014 and was not reported to HIQA, as required by the regulations. The provider failed to take appropriate safeguarding steps and the person against whom the allegations had been made continued to live and work in centre with vulnerable adults and children.

In relation to another allegation, the provider informed inspectors that they had received a recommendation from an external agency that the staff referred to in the allegations should be removed from the centre without prejudice but as a precautionary measure to ensure the safety of residents, pending the outcome of an investigation. Inspectors also saw records of this recommendation. When staff refused to cooperate with this request, the provider took no further actions until required to do so by inspectors.

Inspectors required the provider to implement measures in response to the allegations and to keep residents safe. The initial submission by the provider was inadequate and inspectors had to instruct the provider to identify and implement measures to manage the immediate risks to residents.

The allegations were of such a serious nature that inspectors informed the Gardaí and the National Safeguarding Office of the Health Service Executive.

The purpose of this inspection was to verify whether the provider had implemented effective measures to manage this risk. Inspectors found that the person in charge and safeguarding officer had tried to implement interim measures to improve safeguarding for residents, however they were experiencing significant resistance from some volunteer co-workers. One volunteer co-worker explained to an inspector that they preferred to manage issues in the houses without the "outsiders" such as paid staff, as those staff impacted on the culture of the centre.

Examples of concern included difficulty for managers in accessing residents' records in houses, refusal by some staff in houses to provide information or records and refusal by some staff to comply with basic requests such as the provision of adequate rosters. Inspectors saw that managers were concerned for the integrity of records, had removed documentation from houses and had changed the locks on office doors to ensure the security of the documentation.

Inspectors reviewed the staffing arrangements in each of the houses in the centre. In one of the houses, the provider had identified the need to have a paid, trained staff member to work alongside the volunteer co-workers. However, this had not been put in place at the time of inspection. The provider had also identified the requirement for some volunteer co-workers to be moved from a house as an interim measure while a review of the service was being undertaken. The provider initially stated that this needed to happen with immediate effect as a safeguarding action, but after the inspection, the provider stated that this would not happen until September 2017 which date was not acceptable.

One of the safeguarding measures that the provider stated they would implement was to assign experienced, paid staff to supervise the work of volunteer co-workers in the houses where there were safeguarding concerns. However, on inspection, inspectors found that some of these shifts were being covered by agency staff who did not have an

adequate knowledge of the residents or of the issues involved to have the authority or understanding to enable them provide adequate oversight.

As part of the provider's action plan to manage risk to residents, the provider had reviewed the arrangements for visitors visiting the houses in the centre and had developed a revised policy. Previously, people visited residents and stayed over in residents houses without appropriate consideration of risk or impact on residents. Inspectors saw a record of visitors maintained in one of the houses and saw that visitors who stayed for a number of days were a regular feature in this house. In another house that was reviewed, records of such visits had only commenced recently and it was not possible to identify who had stayed or for what reason. The person in charge was not being informed about all persons staying in the houses and visiting arrangements were made without consultation or approval by management. The person in charge described recent efforts to implement the revised visitors policy with a view to controlling who had access to residents' homes and described a high level of resistance and lack of cooperation in implementing it. This level of unrestricted access to the residential homes in a centre with poor responses to safeguarding concerns is a significant issue.

In another safeguarding matter, inspectors saw evidence where there had been a clinically assessed significant safeguarding risk identified. The provider had not informed the newly appointed person in charge or safeguarding officer and there were no measures in place to manage that risk.

The provision of positive behavioural support was not adequate. Inspectors requested clarity on a specific behaviour of risk for another resident and found that key persons responsible for the resident's care were unaware of the risks and there was no adequate support or intimate care plans which would support the appropriate support and care of that resident..

Judgment:
Non Compliant - Major

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:
Based on the information received prior to this inspection and the findings on inspection, inspectors were concerned that the provider did not have adequate management and oversight arrangements in the centre and did not have full authority in the centre. Inspectors found that the provider was failing to identify safeguarding and other issues for themselves, and when they were identified, was failing to take appropriate action unless required to do so by inspectors.

Inspectors found that the provider had not responded appropriately to allegations of serious abuse within the centre. When they did respond, it was not a sufficient response that prioritised the safety of residents. In addition, the provider had failed to ensure that revised safeguarding arrangements were being implemented, and to take appropriate action to address any resistance to the implementation.

The newly appointed person in charge was suitably qualified and had demonstrated a commitment to implementing a more robust and accountable structure. She demonstrated a thorough understanding of her role and responsibilities in relation to safeguarding and diligently pursued safeguarding concerns as they emerged.

However, the provider had failed to ensure that adequate support was provided to the person in charge to enable her to fulfil her duties in relation to the management and oversight of the service. Examples include incidents which were reported to inspectors of the new person in charge and the safeguarding officer being informed they had to ring and make an appointment to gain access to one house in the centre. They had been questioned as to why they wished to see a resident who was ill in another house in the centre.

Due to the findings and concerns of the inspectors on the day of this triggered inspection, the provider took the additional step of ensuring there were paid employees assigned to one of the houses and undertook a considerable restructuring of other responsibilities among the employed staff to provide a level of oversight. However, this action was only taken when inspectors required the provider to respond.

Inspectors found that the provider had not put sufficient arrangements in place to ensure that staff who wished to raise concerns about the safety of care could do so without obstruction. For example, when issues were brought to the attention of the provider, they did not act in a timely manner, and the management in the centre had difficulty accessing relevant records to complete their review of the safety of care.

Inspectors found that there were inadequate arrangements for the supervision of staff, particularly the volunteer co-workers.

Judgment:
Non Compliant - Major

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

Health Information and Quality Authority
Regulation Directorate

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-0003604
Date of Inspection:	09 May 2017
Date of response:	

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 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Intimate care plans and staffing arrangements and staff understanding of these did not provide sufficient protection for residents.

1. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to

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

ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

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

Proposed Timescale:

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
.the provider failed to
-To take decisive and appropriate action when there was evidence of potentially significant risks to vulnerable residents.
- To adequately and transparently investigate any and all allegations
-To adequately and promptly report any such incidents to the relevant statuary or legal bodies
-To ensure that all persons living and working in the centre adhere to good safeguarding practices and uphold their individual responsibilities
-To respond appropriately to a significant clinical safeguarding risk assessment
-To ensure the arrangements for visitors promoted residents' safety
-To ensure staffing and supervision arrangements were appropriate and carried out by appropriately skilled and experienced staff.

2. 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:

Proposed Timescale:

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:
Systems to ensure that staff could safely and without obstruction raise and identify concerns about the safety of care were not satisfactory.

3. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

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

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was evidence that the governance systems at all levels were not functioning with authority and accountability.

4. 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:

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for effective monitoring, oversight and decision making were not satisfactory to ensure the service was safe.

5. 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:

Proposed Timescale:

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff were not required to take personal and professional responsibility for their actions and the safety of residents.

6. 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:

Proposed Timescale: