

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	Camphill Community Ballytobin
<b>Centre ID:</b>	OSV-0003604
<b>Centre county:</b>	Kilkenny
<b>Type of centre:</b>	Health Act 2004 Section 39 Assistance
<b>Registered provider:</b>	Camphill Communities of Ireland
<b>Provider Nominee:</b>	Adrienne Smith
<b>Lead inspector:</b>	Noelene Dowling
<b>Support inspector(s):</b>	Gary Kiernan
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	19
<b>Number of vacancies on the date of inspection:</b>	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 to inform a registration decision. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 23 May 2017 09:30 To: 23 May 2017 19:30

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

Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management

**Summary of findings from this inspection**

The office of chief inspector had issued a Notice of Decision to cancel the registration of this centre on 22 May 2017 because of on going failure of the provider to address serious safeguarding issues in the centre. Under the Health Act 2007, as amended, the provider has 28 days to appeal the decision to the District Court, should they so wish.

Following this inspection, the provider wrote to the chief inspector to say that they accepted the Notice of Decision and sought the immediate cancellation of the registration. The provider also wrote to the Health Service Executive (HSE), and copied the chief inspector on the letter, informing the HSE that the provider did not have the capacity to ensure residents were safe within the centre, and asking that the HSE take charge of the centre immediately.

The office of chief inspector considered the immediate cancellation of the registration but were requested by the HSE to delay the cancellation until the 6 June 2017 to allow them to put arrangements in place for taking over the operation of the centre. The HSE submitted an action plan to the chief inspector setting out interim measures that they were taking with the consent of the provider, to improve safeguarding in the centre. The plan included the allocation of an experienced HSE manager to the centre, the allocation of experienced, paid agency staff in each of the houses on a 24 hour basis and the allocation of two HSE safeguarding officers to be based in the centre. The HSE informed the chief inspector that they were satisfied that the measures they had put in place would mitigate the risk to residents.

On that basis, with the consent of the provider, the cancellation of the registration

was arranged for 2pm on 6 June 2017.

This report sets out the findings of an inspection which took place prior to the above communications, and was undertaken to verify that the actions taken by the provider since the previous inspection were effective in safeguarding residents from the risk of abuse. Inspectors found that while the newly appointed person in charge and safeguarding officer were attempting to implement revised safeguarding arrangements, they were continuing to experience a significant level of resistance. In addition, the provider had not taken adequate action to support the local managers and to address the issues effectively.

Inspectors found that the provider had not effectively implemented their own plan to improve safeguarding of residents in the centre. Inspectors found that the provider had not responded in a manner that prioritised the safety of residents in relation to emerging allegations of abuse. Inspectors informed TUSLA and the National Safeguarding Office of the HSE about further allegations and risks of abuse to residents. Inspectors confirmed that other matters of concern had been reported to the Gardaí by the person in charge. The provider was also required to take immediate action in relation to significant healthcare and safeguarding risks for residents.

During the inspection, inspectors identified further concerns in relation to restrictive practices and daily routines which could be considered abusive and found that there was a lack of adequate management response to these issues.

As the registration is in the process of being cancelled, the provider has been given an opportunity to address any potential inaccuracies in this report but has not been asked to complete the action plan at the end of the report.

**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:**

When the Notice of Proposal to cancel the registration of the centre had been issued in December 2016, inspectors had required the provider to undertake a review of all allegations or incidents of abuse or staff misconduct. Prior to the previous inspection, the provider had informed the chief inspector of serious allegations of physical and sexual abuse, On that inspection, inspectors had found that the provider had not responded adequately at the time the original allegations were made or when the allegations had been brought to their attention as part of the current review.

In addition, inspectors had identified staff practices and other issues which the provider was not monitoring and the provider had not implemented measures to prioritise the safety of residents.

On this inspection, inspectors found that further historical allegations of serious incidents had been identified including alleged assaults on residents and reports that residents were prevented from accessing bathrooms by locking them into rooms. The provider had not responded adequately to these issues and the person in charge continued to report that there was resistance to implementing revised safeguarding arrangements. Inspectors saw examples where arrangements were being made for visitors to go to the centre without informing the person in charge, and proposals for new volunteer co-workers coming to the centre without adequate vetting and without the knowledge or approval of the person in charge.

Inspectors were informed that an allegation of assault had been made by a resident since the previous inspection. The provider had not responded adequately. The person who was alleged to have assaulted the resident continued to have access to residents

and there had been no screening of the alleged incidents. This issue was addressed by management during the inspection following questioning by the inspectors.

Given the serious nature of the incidents, inspectors informed Tusla and the HSE's National Safeguarding Office and saw evidence which confirmed that the matters had been reported to the Gardaí by the person in charge.

Following the previous inspection, inspectors had been informed of intimate care practices that were intrusive and could constitute sexual assault. Inspectors were informed on this inspection that the person in charge had issued an instruction that this practice was to cease immediately. However, the person in charge was unable to provide assurances that the direction had been followed. She stated that there continued to be resistance to safeguarding measures amongst some staff and there was no way to verify whether those staff had accepted and implemented the instruction.

Another safeguarding concern related to the use of complementary medicines with some residents. Inspectors asked staff to demonstrate how these medicines were applied and the description could be considered intrusive and could constitute sexual abuse. There had been no consideration of this, and there had been no intimate care plan or safeguarding plan put in place to ensure the interventions were appropriate and that the safety of the residents were assured. At the request of inspectors, the safeguarding officer reviewed the practices and following that review, he instructed immediate cessation of the practice.

Inspectors saw that the rights and wishes of some residents were not respected, and some practices could be considered abusive. For example, inspectors saw where a resident had been woken at 5:00 am to participate in a Camphill Community festival. The resident was evidently distressed and while unable to verbally communicate that, the resident was crying and shouting for the duration of the event. This distress continued until the resident was returned to their house some hours later. Inspectors asked staff about why the resident was required to participate in an event that was obviously distressing to them, and were told that it was important for the person to participate in that Camphill Community tradition.

Inspectors also had concerns about the use of restrictive practices. Inspectors saw examples of where residents were removed to a small room when they presented with behavioural issues. A similar example was where a resident was expected to stay in a garden shed when presenting with such behaviour when engaged in outdoor activities. There was no assessment or review of these arrangements. There was no guidelines for staff to demonstrate that the arrangements were based on assessed needs of the residents and there was no evidence that these measures were the least restrictive for the shortest duration. There were no guidelines for staff to ensure consistency in the implementation of any such measures. The manner in which the measures were described to inspectors indicated that they were punitive measures rather than positive behaviour support measures.

Since the previous inspection a resident had experienced significant unexplained bruising to the head. Inspectors found that there was an inadequate response to the healthcare needs of this resident when the injuries were identified. In addition, the provider had

not undertaken an appropriate investigation to ascertain how the resident sustained such injuries, and had not implemented the provider's own protocol around unexplained injuries.

Inspectors saw where there had been a peer to peer altercation which resulted in injury to a resident. This had not been appropriately responded to and the chief inspector had not been notified of the incident, as required by the regulations.

**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):**

No actions were required from the previous inspection.

**Findings:**

Inspectors found that the healthcare needs of residents were not being consistently monitored or responded to.

When reviewing the healthcare response to a resident who had experienced significant unexplained injury to their head, inspectors found that staff in the centre had not responded to the issue when it was first observed but that the injuries were only responded to adequately when observed by staff from another agency.

Following this, inspectors considered a sample of healthcare plans for other residents and found a resident who had a significant chronic infection which had not been reviewed by an appropriate health professional. In the case of another resident who had a significant infection, which caused the resident considerable distress and pain, inspectors found that the resident was not referred for specialist review in a timely way.

Some residents had been reviewed by health professionals who had advised that food or fluid intake for residents should be monitored. Staff did not demonstrate an understanding of the importance of such monitoring for residents who were experiencing weight loss, and had not implemented the recommendations of the health professionals.

**Judgment:**

Non Compliant - Major

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**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):****Findings:**

Based on the findings of this inspection and the information received and reviewed by HIQA, significant concerns remained in regard to the governance and management arrangements in the centre.

The findings in relation to healthcare, safeguarding and the continued lack of full co operation by the staff demonstrated that the provider does not have full authority in this centre.

Despite the efforts of the local management, the inspectors found that this situation had deteriorated further since the previous inspection. The person in charge informed inspectors of increased resistance to measures that management were trying to implement. The provider was not taking sufficient action to enable the person in charge to undertake proper oversight of the centre.

**Judgment:**

Non Compliant - Major

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**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<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Camphill Communities of Ireland
<b>Centre ID:</b>	OSV-0003604
<b>Date of Inspection:</b>	23 May 2017
<b>Date of response:</b>	

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

There was a failure to manage the use of restrictive practices and to ensure that any such practices were based on the assessed needs of residents, were for the shortest duration and were regularly reviewed.

**1. Action Required:**

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

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

**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 ensure that residents were protected and not made additionally vulnerable to or put at risk of abuse.

To take action when there was an identified risk to residents.

To investigate an incident of unexplained injury to a resident

To ensure that residents were not compelled to participate in activities that caused them obvious distress.

**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:**

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**

The person in charge had failed to appropriately investigate allegations or suspicions of abuse and to take action to protect residents.

**3. 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:**

**Proposed Timescale:**

**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 ensure that there was an appropriate intimate care plan for residents and that care practices were carried out in a manner that protected residents from risk of abuse and in a manner that respected the dignity and integrity of residents.

**4. Action Required:**

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to 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:**

**Outcome 11. Healthcare Needs**

**Theme:** Health and Development

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

Medical attention was not sought promptly on an occasion of potentially serious injury to a resident.

Timely and adequate medical review was not sought for residents who had a chronic infection.

The recommendations of health care professionals were not being implemented.

**5. 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:**

**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:**

The management systems were not effective to ensure safe care for residents.

**6. 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:**