

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	Camphill Community Duffcarrig
Centre ID:	OSV-0003610
Centre county:	Wexford
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Paul Henry
Lead inspector:	Noelene Dowling
Support inspector(s):	Raymond Lynch
Type of inspection	Unannounced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	5

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
12 July 2017 10:00	12 July 2017 19:30
13 July 2017 08:30	13 July 2017 15:30

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
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 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background:

This was the fifth inspection of this centre. The registration inspection was undertaken in September 2015 and due to the findings at that inspection further follow up inspections were undertaken in March and July 2016.

A number of changes to the local management structure had taken place in the intervening period. Since the July 2016 inspection, a new person in charge had been appointed but had resigned from post prior to this inspection. A suitably qualified and experienced person had been carrying out the duties of person in charge since 31 May 2017 but no person had been appointed to the position of person in charge at the time of this inspection.

Due to overall safeguarding concerns in the organisation as a whole, a number of regulatory meetings were held with the provider in 2016 and a warning letter was

issued regarding safeguarding systems and governance structures. While there were improvements evident inspectors were not assured that the systems were sufficiently robust to provide consistent safe practice and response to concerns which arose.

How we gathered our evidence:

Inspectors met with four residents, staff and observed practices. Residents who could communicate told inspectors they felt very happy and safe living in the centre. They choose their own activities, daily routines or work, and could tell any staff if they had a problem. Other residents allowed inspectors to observe some of her daily lives and communicated in the own preferred manner. Inspectors also reviewed documentation including policies and procedures, personnel files, health and safety records, residents@ records and personal plans.

Description of the service:

The statement of purpose states that the service is designed to provide long-term residential services for adults, both male and female with moderate intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviours.

Service is provided to 29 residents in eight residential units, accommodating between five and one resident and varying numbers of short-term volunteers who live in the units for agreed time periods.

On the days of the inspection, there were 24 residents living in the centre and one unit designated for four residents was not occupied. The provider informed inspectors that this unit was being removed from the application for registration.

The statement of purpose and application form required amendments to reflect this change in numbers from twenty nine to twenty five residents and the units to be included for registration purposes.

Overall judgement of our findings:

The actions required following the previous inspection, which took place in July 2016, were reviewed. Eleven actions were identified and satisfactory progress had been made on all of these.

Governance arrangements were not satisfactory and did not provide a stable structure for the oversight of the service. There was no appointed person in charge which constituted a significant non compliance in relation to stable and accountable management. Additional local management posts and changes to the management structure were outlined to inspectors, which, if implemented would more realistically reflect the size of the centre and the needs of the residents. Given that the centre has been in the regulatory process since 2014 these actions to support the governance structures have not been taken in a timely manner by the provider. The findings in safeguarding also remain of concern although some improvements were evident.

Positive changes to staffing structures with less dependence on the volunteer or co-worker shared living model had also been made.

Good practice was identified in areas such as:

- Access to meaningful recreation, activities and multidisciplinary assessments, which supported residents' quality of life (outcome 5)
- Healthcare needs and medicines management, which ensured residents' safety and wellbeing (outcome 11 & 12)
- Suitably qualified skill mix and numbers of staff and volunteers whose roles were clearly defined and overseen which promoted improved outcomes for residents (outcome 17)
- Adherence to regulatory requirements to notify The Chief Inspector of significant and untoward events.

Improvements were required in the following areas:

- The appointment of a person in charge
- Risk management and fire safety procedures (completion of works agreed) (outcome 8)
- Implementation of behaviour support plans to maximise the best outcome for residents (outcome 7)
- Training in managing safeguarding concerns which would protect residents(Outcome 7
- Systems to ensure residents privacy was protected (outcome 1)
- Contracts and fees for services (outcome 4)
- Supervision of staff (outcome 14)
- Maintenance and up-keep of premises and grounds (Outcome 6).

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

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

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

Theme:

Individualised Supports and Care

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

No actions were required from the previous inspection.

Findings:

This outcome was not reviewed in its entirety. Improvements were required regarding complaints.

While the complaints policy was in order and complaints were recorded there was a lack of satisfactory outcome. The decision making process was not coherent in some instances. For example, residents had made complaints regarding persons being able to see directly into their bedroom windows. While the complaint was addressed the actions taken did not resolve the matter satisfactorily for the future and for other residents who may experience this lack of privacy.

Residents stated that they could contact any member of staff if they wished to make a complaint and matters would be addressed for them.

Advocates had been sourced for a number of individual residents and advice was being sought to inform systems for assisted decision-making in the future.

It was apparent that residents had choices in day-to-day activities and that routines were centred on their own preferences and wishes. Changes to work and activities were made at their request. There was sufficient transport and staff available to accompany residents to any events of their choosing.

Throughout the inspection staff members were seen engaging with residents in a respectful, caring and relaxed manner. It was apparent that the privacy of residents was respected.

Judgment:

Substantially Compliant

Outcome 04: Admissions and Contract for the Provision of Services

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

Theme:

Effective Services

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

No actions were required from the previous inspection.

Findings:

There was a suitable policy and procedure for admission. No admissions had taken place since the previous inspection and the manager informed inspectors that it was not intended to admit any residents in the near future. This was in order to allow the changes in accommodation and staffing structures to be fully implemented.

It was acknowledged that previous admission process had not been sufficiently robust to ensure the assessed needs of residents could be met in the centre.

While contracts for services were available no signed agreement for services had been provided for one resident who availed of a shared-care transition arrangement. In another instance, the fee to be paid was not identified on the contract.

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

Judgment:

Non Compliant - Moderate

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 actions required from the previous inspection had been satisfactorily addressed. Some further areas for improvement were identified.

Since the previous inspection a review of residents' assessed needs and of the capacity of the provider to meet those needs within this service had been undertaken in conjunction with relevant allied services.

From a review of seven residents personal plans and other documentation inspectors were satisfied that there was good access to multidisciplinary assessment of residents' needs. A number of these had been accessed privately by the provider to avoid delays for residents. Assessments included speech and language, physiotherapy, psychiatry, sensory, optical and audiology.

There were detailed personal plans available for the residents, which were reflective of their assessed needs and personal aspirations. It was apparent that the residents contributed to these plans in their preferred manner, with supports and were consulted regarding their care end and life-style preferences.

Annual multidisciplinary reviews had taken place for most but not all of the residents. Where they occurred there were frequent internal reviews of need and progress with the involvement of the allied services. The reports and minutes of these meetings were very detailed and encompassed all of the residents' need and wishes.

However, there were some areas where recommendations made by clinicians had not been implemented across all units. This was pertinent to residents with complex needs who required the use of pictorial images or communication systems for example. In addition, some basic goals, such as going swimming identified by residents had not been implemented.

Two transitions/discharges to other services had taken place. One of these was managed in a rushed and less than suitable manner. It is acknowledged that unforeseen circumstances influenced this occurrence. The second transition was managed in a supportive and well-planned manner with the full participation of the resident and family,

Families and or representatives of the resident were involved in the review and assessment process where this was suitable.

There had been a noted improvement in the collaboration and sharing of information with external agencies to better support resident's care when they were not residing in the centre on a full-time basis.

There was evidence that the personal plans were focused on improving residents quality of life overall. Steps to allow meaningful goals such as further integration with peers or into the community were being taken in some instances with careful monitoring evident.

In the main inspectors found that residents social care needs were supported. They had

good access to activities in the local communities such as visiting the local towns for events and amenities, cycling, shopping, special Olympics.

The day-to-day activities were chosen by residents themselves and there was evidence of good communication between the units and the various workshops or courses they attended to ensure they remained relevant and meaningful for the residents.

There was evidence that where residents expressed or demonstrated that they were no longer happy with these plans they were altered to reflect this.

They participated in the life of the units and shared tasks with staff including housekeeping.

Judgment:

Non Compliant - Moderate

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):

No actions were required from the previous inspection.

Findings:

This outcome was not reviewed in its entirety as the premises had been reviewed at the registration inspection. The residential accommodation for which the application was made is comprised of eight houses with one stand alone apartment attached to one of the houses. This is being reduced to seven units by the provider.

The three story unit was not been used at the time of the inspection. It was deemed no longer suitable without significant remedial works to meet the needs of the residents, in particular those residents who were developing age related mobility issues.

Two issues were noted in relation to the grounds and premises. In one unit, the laundry facility was not accessible from the inside of the unit. The facility itself required significant improvement with unsealed and uneven cement flooring and walls, which posed a risk of infection and injury.

The grounds in general required maintenance but in one unit, the grass and weeds were growing right up to the doors.

A schedule of maintenance and repair was being undertaken.

There were adequate sitting, recreational and dining space separate to the residents' private accommodation and separate communal areas, which allowed for a separation of

functions and there was space for private time and visits.

Judgment:

Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:

Effective Services

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

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

Findings:

The actions required from the previous inspection had been partially but not fully completed. Some improvements were still required in the on-going management of risk across the units.

A long-term structural fire safety improvement plan had been agreed with the local fire authority in 2014. Works had been continuing since then but the provider could not demonstrate the precise works which were completed, and those which remained outstanding at the time of inspection. Inspectors were therefore not assured that the appropriate works had been prioritised.

Inspectors were informed and saw that all units had fire alarms and emergency lighting installed or upgraded. However, while some fire doors had been installed in crucial areas these were not installed in all relevant areas to ensure safe evacuation of residents. Emergency lighting was not serviced quarterly as required.

Risks were identified from a a review of PRN (administered as required) emergency medicines. The protocols for these medicines were written by staff. One protocol did not correlate with the prescription available and in another did not guide staff as to the timing and maximum dosage of the medicine. When these were brought to the attention of the house coordinators and rectified promptly. However there was a significant risk to the residents from the lack of attention to details of these protocols.

There was evidence that all incidents or accidents were reviewed and a register of all such events was maintained. Audits of untoward events including medicines errors were maintained. Thirteen non-administration errors had occurred in a three-month period in 2017. While effective actions had been taken in one unit this had not been assimilated into practice in all units to avoid repetitions of the incidents. The system for learning and review therefore required some improvements.

The action from the previous inspection in relation to training for staff, especially night

duty staff in fire safety and the systems for managing risk including self-harm had been addressed promptly.

Inspectors saw individual risk assessments and support plans which had been devised for residents. These were detailed and gave appropriate guidance to staff to manage identified risks and take preventative actions. Where required, falls assessments and transporting plans were available and staff were familiar with these plans.

Pertinent personal evacuation plans were available for the residents. However, these did not detail the precise support needs for residents but these were accurately detailed in the unit based fire evacuation plans. The health and safety officer undertook to rectify this. Staff were clear on the procedures to be used should evacuation be required. All new staff including those responsible for overnight care were inducted into these plans.

Training in the management of choking incidents had been provided for staff as required and there was appropriate guidance available for staff in relation to this.

The risk management policy was in accordance with the regulations and a detailed risk register was maintained and updated.

There was a current and signed health and safety statement available. Evidence of roadworthiness was available for all vehicles identified for use.

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):

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

Findings:

Inspectors found that the actions required from the previous inspection had been satisfactorily resolved. There was evidence of access to behaviour support specialists for assessment of need and implementation of management plans.

Restrictive practises had also been reviewed and where used they were seen to be clinically overseen and implemented only as a last resort in the absence of any suitable

alternative for residents' safety. However, some improvements were still required in systems to manage specific behaviours that challenge and to ensure staff had the capacity to implement the programmes effectively.

This was evident from the information in daily logs and reports, which described residents' behaviours using inappropriate terms and did not demonstrate that they were adhering to the management plans in an objective manner as outlined. Records of the behaviours were not being maintained sufficiently to demonstrate the nature of the behaviour and these focused mainly on staff's personal response to the behaviours presented.

Where accusations or threats of an accusation were made, it was evident that they were not fully reviewed and managed within a framework of safeguarding. There were no multidisciplinary response agreed and appropriate thresholds for identifying when such incidents required a safeguarding response and when they did not. While inspectors acknowledge the complexities involved in the incidents this placed the residents at risk of potentially abusive interactions with staff.

Further incidents of allegedly abusive situations relating to both staff and or peers were managed in accordance with the policy on the protection of vulnerable adults. Timely and suitable safeguarding actions and plans had been implemented by the local manager in such instances. Reports were made to the relevant statutory agencies as necessary.

Previous inspections had found that a process used to manage a number of allegations was not satisfactory. This had been externally reviewed on two occasions. Both reviews made specific recommendations as to the correct process to be used and the need for additional training for personal who undertook such investigations and adherence to the policy on the protection of vulnerable adults and Trust in Care procedures. The provider had commissioned the second report as the findings of the first indicated that the process used for the investigations were not in accordance with correct procedures. The provider informed inspectors following the inspection that recommendations made had been acted upon and further actions would be implemented following the inspection. The findings outlined in paragraph four indicate that the oversight of correct safeguarding procedures is still required.

Overall inspectors were satisfied that residents finances in particular those who needed support with their finances were managed well and detailed records of any transactions were maintained. However, there was no effective system for oversight of this.

No children were living in the residual units. A number of children resided in accommodation with parents on the campus. There were detailed safeguarding plans implemented.

The policy on visitors, in particular persons who wished to stay overnight had been revised in accordance with the HIQA requirements for this service nationally. Visitors were not permitted to stay in the residential units and their presence on the campus required the permission of the person in charge.

The personal intimate care plans for residents were suitable and took account of the residents' need for privacy, dignity and integrity to be maintained. Staff were able to tell inspectors about these procedures.

From observation, staff were respectful and supportive of the residents and the residents assured inspectors that they felt safe living in the centre, well cared for and that they would expect to be.

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:

The inspector found that the person in charge had complied with the responsibility to forward the required notifications to the Chief Inspector.

Judgment:
Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

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

No actions were required from the previous inspection.

Findings:

The provider was compliant with this regulation. Residents' overall healthcare needs, including nutritional needs, were met and residents had access to appropriate medical and allied healthcare services. There was good access to GP services with regular reviews evident. Where a specific support plan for healthcare needs was required, it was

available and staff were familiar with the protocols required.

In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists, physiotherapy, neurology 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 and there were support plans available where such treatment was a cause of anxiety for residents.

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. As observed by inspectors and confirmed by the residents the food was nutritious, fresh, choices were accommodated and the mealtimes were social and inclusive occasions. Residents helped to prepare the food with staff assistance where this was necessary and had full access to the kitchens and catering equipment in the houses. Where specific dietary needs or support with eating and dining were identified by dieticians these were found to be adhered to. Adapted crockery and utensils were available as needed to encourage independence.

A policy on end of life care was in place. Some arrangements had been made however and residents were aware of these plans.

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 medicines policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines. Staff were trained in medicines management and inspectors were informed that only those trained were allowed to dispense medicines. Where emergency medicines were required, there were systems in place to ensure staff that were trained in its administration and were readily available to do so.

Inspectors were informed that no residents were assessed as being able to manage their own medicines at the time of the inspection.

Residents' medicines were securely stored and there was a robust key holding procedure.

Some issues were noted in relation to the management of medicines errors and emergency protocols. These are actioned under Outcome & Health and Safety.

Judgment:

Compliant

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

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

No actions were required from the previous inspection.

Findings:

The statement of purpose had been forwarded to HIQA as part of the application for registration. At this time the statement required a number of changes to include changes to the structures and the governance systems. Admissions to the centre and care practices as seen were congruent with the statement of purpose.

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):

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

Findings:

The action required from the previous inspection had been resolved with more robust staff deployment arrangements and staff who had sufficient knowledge of residents available to provide care. Arrangements to ensure the volunteers were aware of their responsibilities and oversight role in the units had also been improved.

However, there was no person appointed to the post of person in charge at the time of this inspection. This is a legal requirement under the regulations. The previous post holder had left the role in May 2017 and a member of the local management team was acting as manager while a recruitment process took place. The provider was informed that this deficit had to be rectified promptly and a recruitment process had been implemented. Inspectors were assured this would be dealt with and following the inspection details of the appointment of a suitably qualified and experienced person were forwarded.

However, the findings in safeguarding and risk management indicate that there has not been sufficient oversight and actions taken to ensure the sustained safe and effective delivery of care. While there was a line management supervisory system implemented for all grades this was not consistent or effectively implemented for all staff. Issues identified in outcome 8 (safeguarding) regarding staff response to behaviours that challenge had been addressed in an informal manner without due process and inclusion in the recorded supervisory process. There was no framework therefore for management to ascertain the outcome of the process. Lack of such action has been a feature in a number of inspections in the organisation and in this centre. It is also contrary to the provider's safeguarding plan as submitted to HIQA.. Where such supervision was undertaken it was satisfactory.

Plans were outlined to the inspectors regarding the recruitment of two further deputy managers, a suitably qualified nurse and a new regional manager. Each will have specific areas of responsibility. These arrangements were intended to reflect the size and complexity of this centre. However, it is apparent that these additional arrangements are necessary in order to ensure effective governance.

There were formal reporting systems evident between the unit coordinators and the acting person in charge, which were found to be detailed and focused on residents' care. There was clarity of roles and responsibilities evident with lines of accountability to the provider also evident.

The provider had undertaken the required two unannounced visits to the centre since the previous inspection. An action plan had been agreed following the most recent visit but this had not been implemented at the time of the inspection. The annual report for 2017 was in process and was forwarded following the inspection.

Judgment:

Non Compliant - Major

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):

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

Findings:

Changes had been made to the staffing structures and skill mix and further development of this was outlined to inspectors. This change was undertaken to reflect the diverse, complex and changing needs of the residents.

The workforce comprised of volunteers who lived in the units for a period of one or two years and employed qualified staff. Each unit had a suitably qualified house co-ordinator and in most units a deputy co-ordinator and additional qualified staff. A number of residents were supported by employed staff only due to their specific need for support. The presence of the volunteers provided additional support and activities for residents.

Improvements had also been made to the availability of qualified personnel at weekends and overnight to ensure there was oversight and support for staff in the centre. The provider told inspectors that they were currently recruiting a qualified nurse to provide clinical and healthcare support for residents.

Inspectors found that the numbers and skill mix in this instance was satisfactory and the findings of the inspection are reflective of this change to the staffing structure. On this inspection the duties of both staff and volunteers were clearly defined with levels of accountability and oversight now evident.

From the training records made available inspectors found that staff had the required training in the management of behaviours that challenged. All other mandatory training was provided with any shortfalls already scheduled for.

From a review of a sample of both volunteer and staff recruitment files inspectors found that the systems were satisfactory with the required documentation sourced prior to commencing duty.

However, the recruitment of the volunteers was not overseen by the person in charge. As these volunteers, who live in the units have significant access to residents and provide various levels of support this posed a potential risk in terms of the suitability of these persons for the positions. This was discussed with the acting person in charge at

the time of the inspection. A small number of consistent agency staff was used.

Care group meetings were held weekly and the records of these indicated that they were used to monitor practices and focused on residents care needs and implementation of interventions.

Staff were found to be supportive of the residents, informed on their care needs and preferences and their own responsibilities in relation to these.

Judgment:

Substantially Compliant

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 report¹

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003610
Date of Inspection:	12 July 2017
Date of response:	03 August 2017

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Windows in units did not offer residents privacy and dignity when in their bedrooms.

1. Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living

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

space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

Residents have been consulted in respect of the windows and their privacy and dignity. They have been offered a choice to have net curtains, blinds or to have frosted window film on their windows. The necessary improvements will be made having regard to the residents' preferences.

Proposed Timescale: 04/09/2017

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

No signed agreement for services had been provided for one resident and another did not have the charges for services agreed.

2. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

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

A meeting is being arranged with the service user transitioning into the service and his family to ensure there is an agreement of services in place.

Person in Charge to undertake a review of all service users contract to ensure they accurately reflect the charges for services.

Proposed Timescale: 31/08/2017

Outcome 05: Social Care Needs

Theme: Effective Services

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

Goals and aims arising from the personal planning review and assessment process were not consistently implemented.

3. Action Required:

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

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

To ensure consistency a goal setting template has been developed and an action plan resulting from the service users goals developed and adopted for all service users. Clear guidelines in relation to goal development, effective implementation and recording of this including the capturing of recommendations from clinicians are being developed. This will be developed with staff through training and peer learning and implemented through the review process with all service users in their personal plans.

Proposed Timescale: 30/11/2017

Theme: Effective Services

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

Discharges or transfers to other services were not consistently undertaken in a supportive manner.

4. Action Required:

Under Regulation 25 (4) (b) you are required to: Discharge residents from the designated centre in a planned and safe manner.

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

All future discharges or transfers will adopt the person centred principles and template which was identified by the inspector as having been positively implemented transition plan(Jan-Feb 2017) in line with the service user's wants and needs.

These have been shared with all house co-ordinators who may be involved in discharge or transition planning. Completed 25/07/2017

Proposed Timescale: 25/07/2017

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 grounds and one of the laundry rooms was not maintained in a satisfactory condition.

5. Action Required:

Under Regulation 17 (1) (b) you are required to: Provide premises which are of sound construction and kept in a good state of repair externally and internally.

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

The laundry room is to be renovated, this will include painting, rearranging the room, putting tiled floors in place, and providing a means of access through the main house.

Proposed Timescale: 15/10/2017

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 to identify and respond to risks identified were not sufficiently implemented. These included medicines administration protocol and errors.

6. 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:

The protocols for the administration of PRN medications have been reviewed by house co-ordinators and GP's to ensure that protocols and the prescriptions correlate. The template used for protocols to be reviewed and adapted for individual service users.

Proposed Timescale: 31/08/2017

Theme: Effective Services

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

Fire containment doors were not installed in some of the areas required to prevent the spread of fire and allow for safe evacuation.

7. Action Required:

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

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

See response to Action 7 above.

Works to commence on the remaining fire doors in September 2017 and will be completed no later than 03/03/2018

Proposed Timescale: 03/03/2018

Theme: Effective Services

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

To complete the works as detailed in the fire safety improvement plan agreed with the local fire authority in 2014 and provide effective fire safety management systems including suitable fire doors in the required locations.

8. 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 Person in Charge met with the Fire Engineer and a report was completed identifying the fireworks that have been completed and those that remain to be carried out.

Person in Charge met with Senior Assistant Chief Fire Officer on the 29th of July 2017 with the view of reviewing risks assessments and schedule of works in fire safety.

The Senior Assistant Chief Fire Officer has committed to undertaking a review of all planned works and will provide a report detailing priority works. The Senior Assistant Chief Fire Officer advised that all remaining fire doors should be put in place as soon as possible. The Provider has committed to these works. The Person in Charge met with the building contractor on 2nd August 2017 to agree a schedule for the remaining fire doors. Works to commence on the remaining fire doors in September 2017.

An assurance has been received from the Provider in respect of funding of these works and the remaining recommendations from the Senior Assistant Chief Fire Officer's report will, upon receipt, be scheduled and undertaken.

Proposed Timescale: 31/03/2018

Theme: Effective Services

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

Emergency lighting had not been serviced quarterly as required.

9. Action Required:

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

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

Emergency lighting has now been serviced; this is now scheduled to occur quarterly.

Proposed Timescale: 17/07/2017

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:

To ensure that staff had the skill and understanding to respond and objectively implement positive behaviour support plans .

10. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

Staff supporting service users with complex behavioural support needs to receive training from the behavioural support specialist and psychotherapist. Referral accepted by a psychotherapist

A social care qualified staff member will be employed to support a house where a person with complex behaviours resides this person will also receive training.

Proposed Timescale: 27/10/2017

Theme: Safe Services

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

- To ensure that persons responsible for undertaking investigations of allegations of abuse had appropriate training and knowledge to carry out such investigations..

- Agreed and appropriate thresholds for identifying when incidents of behaviours that challenged required a safeguarding response were not implemented.

11. 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:

Trust in Care training completed by Person in Charge 26/07/2017. Further TiC training will be arranged for any persons who may be required to undertake investigations of allegations of abuse.

A Case Review Panel has been established with MDT and senior management input to review the most challenging cases and provide oversight of incident management. This Panel will continue to meet quarterly. At its first meeting the clinical safeguarding framework required for one resident was reviewed and appropriate thresholds proposed while ensuring all concerns raised of a safeguarding nature are, and will be, responded to as per safeguarding vulnerable adults policy. This framework will be kept under review with the Behaviour Support Specialist guiding practice. Completed 18/07/2017. Follow up work is in progress with Behaviour Support Specialist to further develop recording skills and strengthen implementation of appropriate planned response to behaviour that challenges.

Proposed Timescale: 15/08/2017

Theme: Safe Services

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

There was no robust system for oversight of the management of residents finances.

12. 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:

Monthly bank statements have now been requested from the bank for all service users in receipt of finance management support. The statements will be checked monthly against receipted expenditure by house coordinators. The finance administration officer will exercise oversight by monthly audit that will ensure that

o All receipts are kept

o All money is accounted for

o All bank transactions reconcile with bank statements

Monthly reconciled ledgers will be in place for all service users to reflect all transactions and be signed off by the finance administration officer.

Random audits of residents' managed finances will be conducted on a 6 weekly cycle by the deputy Person in Charge with oversight of these by the Person in Charge.

Proposed Timescale: 29/09/2017

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:

There was no person appointed to the role of person in charge at the time of the inspection .

13. Action Required:

Under Regulation 14 (1) you are required to: Appoint a person in charge of the designated centre.

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

The person who was acting Person in Charge at the time of the inspection, pending outcome of interviews, has now been appointed the Person in Charge. - Completed

Proposed Timescale: 17/07/2017

Theme: Leadership, Governance and Management

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

The current management structures and arrangements are not sufficient given the size and complexity of the centre.

14. 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:

A new management structure as outlined to the inspector at the time of inspection is being put in place. A new Person in Charge has been appointed and recruitment of a nurse and 2 Deputy Person's in Charge which is in progress.

Proposed Timescale: 20/10/2017

Theme: Leadership, Governance and Management

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

Staff supervision systems were not consistently implemented to support staff to carry out their roles in professional manner.

15. 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:

A staff and volunteer supervision and appraisal schedule has been put in place ensuring all staff and volunteer receive regular supervision. Completed.

Supervision has been added to the agenda of management and welfare meetings to ensure the implementation of the supervision schedule for all personnel. Completed.

All staff providing supervision to receive formal supervision training to improve the quality of supervision in the community. Due to take place 08/9/2017.

The appointment of 2 deputy PICs and 1 nurse will further strengthen the supervision structure in place.

Proposed Timescale: 20/10/2017