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 Kyle
Centre ID:	OSV-0003625
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):	Paul Pearson
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
Number of vacancies on the date of inspection:	1

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to 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:
15 November 2016 10:00	15 November 2016 18:30
16 November 2016 08:30	16 November 2016 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 02: Communication
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
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

This was the fourth inspection of this centre. The registration inspection was undertaken on 19 April 2016. As result of the findings of that inspection a follow up was required to ascertain the provider's level of compliance and inform the registration decision. An immediate action plan was issued to the provider following that inspection in relation to training in medicines management and the management of choking incidents.

As a result of unsolicited information received by HIQA an unannounced triggered inspection was undertaken on 22 August 2016. That inspection found further non compliances in safeguarding, implementation of crucial aspects of personal plans for residents and also in the level of qualified and experienced staff to support residents with complex needs.

As a result of concerns regarding overall safeguarding and governance arrangements in the wider organisation, the provider was requested to attend meetings with HIQA

in April 2016 and on 16 October 2016. Following these meetings warning compliance notices were issued to the provider. The provider was requested to and submitted a plan to improve safeguarding systems within the organisation. This was duly received and regular updates were provided. Significant areas of the plan have been addressed at the time of this inspection. These included the appointment of a deputy national social care coordinator, systems for incident monitoring, training for managers in safeguarding procedures and the appointment of a fulltime national safeguarding officer.

How we gathered our evidence:
Inspectors met with 10 residents and spoke with 5 residents. Other residents communicated in their own way and allowed inspectors observe some of their daily life and routines. Residents who could communicate stated that they were happy, that "everything was going OK" for them and that they were doing activities they liked to do and that staff sorted out any issues they had for them.

Inspectors also met with staff members, the person deputising for the person in charge and the national safeguarding officer. Inspectors reviewed documentation including policies and procedures, personnel files, health and safety documentation, residents' records and personal plans.

Description of the Service:

The statement of purpose states that the service is designed to provide long term care for up to 17 adult residents, both male and female, of moderate intellectual disability, autism and challenging behaviours. It is situated in its own grounds in a rural location some miles from the nearest village with a total of five units which accommodate between one and four residents. The premises is suitable for purpose. On the days of the inspection there were 16 residents living in the centre.

Summary of our findings:

Inspectors reviewed the 27 actions required from the inspection of April 2016 and found that 14 of these had been addressed, progress had been made on a further 9 actions and four had not been satisfactorily addressed.

Those not resolved included effective governance, risk management and safeguarding and suitable staffing although the direct level of risk had reduced and outcomes were of moderate as opposed to major concerns.

The findings are however influenced by a number of factors including:
The post of person in charge was in an acting capacity
The level of volunteer's/co-workers with limited availability and oversight by fulltime qualified and experienced staff.

Overview of our findings:
Inspectors acknowledge that changes had been made to address substantial issues such has staffing levels and accommodation in some instances. However, these were

recent developments and the impact cannot as yet be fully ascertained.

Overall, inspectors were not satisfied that the provider had put effective systems in place to ensure that the regulations were being met. This resulted in poor experiences and potential risk for residents in some cases, the details of which are described in the report.

- Risk management procedures which were not sufficiently proactive and responsive to ensure residents safety (Outcome 7)
- Behaviour management and support systems were not consistent or sufficiently responsive which impacted on residents overall wellbeing (outcome 8)
- Lack of multidisciplinary reviews to inform practices when circumstances changed or deteriorated
- Lack of suitable skill mix and deployment of staff which did not ensure consistency and quality of care for residents (outcome 17)

Good practice was found in:

- Access to healthcare which promoted residents well being (outcome 11)
- Social care needs and development which supported residents quality of life and experience (Outcome 5)
- Systems to support residents to communicate (outcome 1)

These issues are covered in more detail in the body 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 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):
The action(s) required from the previous inspection were satisfactorily implemented.

Findings:
This outcome was not reviewed in its entirety but inspectors did review the systems for the management of complaints and found that overall issues were addressed and dealt with satisfactorily.

Policies were in place for managing residents' personal property and finances. Residents were encouraged and supported to remain in control of their own finances where this was deemed appropriate and records of spending on behalf of residents were maintained.

An advocate had been sourced for a resident where this was deemed necessary.

Judgment:
Compliant

Outcome 02: Communication
Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:
Individualised Supports and Care

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

Findings:
The actions required from the previous inspection had been satisfactorily resolved. All residents who required support had been assessed by speech and language therapists and there were communication plans available. Residents personal plans held communication needs analysis and guidelines for staff in the use of visual aids. Pictorial images were used effectively to help residents communicate and staff to communicate with the residents. Two staff had received training in sign language and this was being introduced to other staff to ensure they could communicate effectively with the residents.
Staff were observed to be knowledgeable of the residents' verbal and non verbal communication.

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

Findings:
Both actions from the previous inspection had been resolved satisfactorily. No new admissions had taken place but from a review of the documentation in relation to proposed admissions the process was satisfactory to inform effective decision making.

A suitable formal contract for the provision of care and the services to be provided was issued to the resident and or their representative for signing. An easy read contract was also available for the residents. There was transfer information available should a resident require transfer to acute care services.

Judgment:
Compliant

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-

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

Theme:
Effective Services

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

Findings:
There were 6 actions required from the previous two inspections. These included the details and implementation of personal plans, access to and inclusion of multidisciplinary assessments in the personal plans and annual reviews which were informed by multidisciplinary assessment.

There was evidence of improvement but some progress was still required. There was evidence that the personal plans had been reviewed. While the majority reviewed were informed by the assessed needs of the residents' this was not a consistent finding. Significant areas such as supports needed for eating, social and activity based programmes and self harm were not available or sufficient to guide staff.

The house coordinators were however, in the process of reviewing the plans to ensure they were in accordance with the residents' needs and that goals set were suitable and monitored. Medical issues including monitoring of residents weight, required following the previous inspection were being monitored by the centres nurse.

Improvements were evident in residents' access to suitable multidisciplinary assessments. These included speech and language, physiotherapy, psychology and mental health. Records of annual reviews also showed that they were taking place and that they were informed by the multidisciplinary assessments undertaken.

There was evidence that residents where possible and relatives were involved in reviews and planning arrangements and appropriate external personnel also attended where feasible.

However, consultation processes were not consistent, especially where residents were more vulnerable by virtue of disability or lack of involved significant persons. For example, there was no cohesive consultation undertaken with either professionals or family for one resident in relation to behaviour supports or changes of accommodation. No review had been held to either decide on the most appropriate course of action or agree cohesive interventions during a particular period of distress for a resident.

There were however improvements noted in residents' access to meaningful daily

routines and social activities based on their ability and preferences. Some routines had been altered for example, weaving or pottery had been discontinued and the inspector was informed that further reviews of the suitability and availability of such activities was being undertaken for individuals.

Staff were allocated to support residents and ensure they had improved access to activities outside of the units and the centre. This was being monitored by the coordinators. Some residents attended formal art and photography classes and others participated in work on the farms and gardens. Some went horse riding and did photography classes and swimming. Summer holidays had been arranged for the residents.
The personal plans were available in an accessible format for the residents.

Judgment:
Non Compliant - Moderate

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

Theme:
Effective Services

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

Findings:
There were 6 actions required following the previous two inspections. These had been partially but not fully resolved. Inspectors found that there continued to be a lack of oversight and attention to the dynamic and timely process of managing risk.

There was evidence from records and incident reports that where risks had been identified actions had not been taken in a timely manner.

This is evidenced by the following:
The records showed that on five occasions since the inspection in April 2016 a resident had left the centre at various times including at four and five am.
While the resident came to no direct harm, remedial actions such as the employment of waking night staff were only taken on 22 June 2016. Further incidents occurred and were only responded to by the installation of sensors on some doors or windows in September 2016.

While there were suitable evacuation plans plans for most residents no arrangements had been made to support a resident to evacuate from a single occupancy two story unit, following the removal of direct staff supervision in September. In addition, there was no suitable arrangement made for the residents' night time security as the access

door was not locked at night which could place this resident at risk from unauthorised persons.

Systems for learning and review of incidents remained unsatisfactory. While data on incidents and accidents was collated no analysis was undertaken to indentify timescales or causal factors which may have contributed. However, where issues were seen to be contributing to incidents such as lack of stable experienced staff no remedial actions were taken.

This was also the finding in relation to medicines management errors. Fourteen had taken place in 2016. These were primarily omissions or in some instances duplicate administration. While there was latterly a system for checking the administration of medicines, incidents still occurred which demonstrated that the systems were not effective.

There were fire safety issues identified at the previous inspection including the provision of emergency lighting and adequate fire doors. While these had been addressed promptly inspectors saw that a lock had been removed from a compartment door leaving a large gap in the door which negated the value of the door to contain smoke.

Other fire safety management systems were found to be good with equipment including the fire alarm, extinguishers and emergency lighting installed and serviced quarterly and annually as required. There were regular fire drills held at various times of the day. These were reviewed for effectiveness and issues identified such as the capacity of the resident to respond. Specific arrangements were made for very dependant residents.

As required by the immediate action plan issued to the provider in April 2016 staff now had training in fire safety. A small number of newly recruited volunteers who did not have this training had been inducted in the systems and further training dates were scheduled. Management of choking incidents had also been provided and staff were able to explain this to the inspectors.

The external doors to most units which inspectors found had been left open all night presenting a significant risk to residents were seen to have been fitted with suitable locking systems

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
There were three actions required from the previous two inspections. Two of these had been satisfactorily resolved but inspectors found that practices and actions in regard to the support of residents with behaviours that challenge were not satisfactory to support and protect residents.

Record and incidents reports demonstrated that a significant level of challenging behaviours, self harm and assaultive behaviours had been occurring. There was evidence that mental health and behaviour support specialist advice had been sought. At the time of the inspection a further behaviour support review was in process for one resident.

However, the outcome of these interventions for the residents was impacted upon by a number of factors. These included the lack of consistent availability of experienced and trained staff, lack of cohesion in implementing the strategies or in formulating the strategies to be used, and lack of oversight of the plans.

In one instance three different behaviour support plans were being implemented for one resident. However, as these were described to inspectors staff were not consistent in implementing them or in how such strategies should be implemented based on residents capacity to respond.

Sensory therapeutic interventions prescribed by appropriate professionals were used in some instances inappropriately without sufficient understanding of the purpose to enable them to be of most benefit to the residents. For example, a weighted therapy blanket was used at night as opposed to at periods during the day to reduce the resident's anxiety. The strategies were also used for set periods during the week as opposed to being incorporated into the residents' daily life. Usage as opposed to impact and benefit for the residents was being recorded. These findings indicate that despite the training available to staff in the management of challenging behaviours further guidance and monitoring was required.

Inspectors saw references in medical records expressing concern as to the capacity and skill mix of staff to provide suitable care for some residents. It is acknowledged that a number of residents were allocated one to one staff ratios to support them. and this could be seen to be of benefit to them.

The inspectors acknowledge that at the time of inspection changes had been made to accommodation and to the provision of more stable staffing in one instance. This did appear to be having a beneficial impact. This had not been undertaken in a timely manner however.

Considerable work had been done in reducing and removing the number of restrictive practices, including unsuitable audio alarms and the use of locked internal doors. The inappropriate locking of corridors to prevent residents leaving sections of the units and to support staff breaks had been discontinued in the week before the inspection.

Alternatives, including the use of door sensors with staff assigned to monitor movements had been sourced and installed. In this way the residents were protected without undue restrictions on their movement and privacy.

There was a suitably qualified designated protection officer and the policy was in accordance with the Health Service Executive policy on the protection of vulnerable adults. Issues which had been raised had been managed and reported accordingly. A resident told inspectors of a concern which the resident was satisfied had been managed well and satisfactorily. Residents who could communicate informed inspectors that they felt very safe and well cared for in the centre.

Inspectors reviewed arrangements for residents' finances and in particular oversight of spending and found the systems had been revised and were satisfactory on this inspection.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors found that the person in charge had not complied with the responsibility to forward the required notifications to the Chief Inspector. Deficits included seven unauthorised absences.

Judgment:
Non Compliant - Moderate

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. Resident's health care needs were reviewed as required. There was good access to GP services. Regular reviews of resident's health were undertaken and from a review of daily records, inspectors found that there was a prompt response by staff to changes in resident's health.

Where a specific care plan for health care needs was required it was available, detailed 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, 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.
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 with staff and residents sharing all meals together. 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 and the apartments.
Where specific dietary needs or supports with eating and dining were identified by dieticians these were seen to be adhered to.

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):

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

Findings:
There were two actions required from the previous inspections. The unsafe transcribing practices had been discontinued and more appropriate and detailed administration records were made available. However, the protocols for the administration of emergency medicines for either seizure activity or sedative use remained unclear and did not correctly guide staff in the administration of such medicines. This and the systems to prevent and respond to medicines errors are actioned under outcome 7 Health and Safety.
Medicines were reviewed regularly by the prescribing clinicians. Most mediation was dispensed in blister packs to support the non nursing staff. There was identification of medication on each of the medication dispensing blister packs.

There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines. Any medication to be administered in an altered format was correctly prescribed.
Residents' medication was stored and secured in a locked cupboard in each premises.

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

Judgment:
Compliant

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

Theme:
Leadership, Governance and Management

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

Findings:
The statement of purpose had been forwarded to the Authority as part of the application for registration. 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
Inspectors found that while there were governance structures in place, evidence of oversight, monitoring and timely decision making was not yet satisfactory. The continued findings in safeguarding, risk management and staffing do not indicate that the systems for governance are robust or accountable.

The person in charge had been appointed to the post in an acting capacity in July 2016. However this arrangement does not meet the requirements of the regulation in terms of length of management experience and training. This was discussed with the provider nominee who stated that recruitment would take place to fill this post.

There had also been changes to the persons acting as house coordinators since the triggered inspection in August 2016.
No unannounced visit had taken place to the centre since March 2016 which is of concern given the changes in governance structures and the number of incidents being forwarded to senior management via the newly implemented national incident monitoring systems.

An annual report governing the period March 2015 to March 2016 had been forwarded following the registration inspection. Other systems for learning and informing practices changes had been implemented as stated in the provider's safeguarding action plan. These included collaborative learning groups and learning notices. However, inspectors found that these were not assimilated into this centres practise. Some of these findings may be attributable to the current status of the post of person in charge.

The provider had, as agreed, employed a suitably qualified person as deputy national social care coordinator to provide support and oversight to the individual centres. There was no outcome of survey of either relatives or residents available at the time of this 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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There was evidence of some improvements in the availability of qualified staff and less dependence on volunteers to provide care for the residents.

However, this was a recent development and the deployment arrangements to ensure this was beneficial remained unsatisfactory. The figure available to inspectors showed that the current ratio of volunteers was 18 support care workers to 16 employed staff with direct responsibility for care delivery or management.

There was a qualified coordinator in each unit although the personnel had changed since the previous inspection. There was now a deputy coordinator in two units. Although the inspector was informed that in order to ensure there was sufficient support and oversight the duty rosters of these staff had been amended to provide cover for day and late evenings. This was not in fact the case with only two of the staff working outside of office hours. There was no change therefore to the dependency on the co-workers/volunteers to manage form 5pm each evening on most days.

It was evident from a review of rosters and incident reports and from speaking with staff that since the inspection in April volunteers had struggled to support residents and manage significant episodes of challenging behaviours. This had impacted on resident care. While staffing was referenced in a number of incident reports no satisfactory action had been taken to address this.

The provider was aware of these concerns, as they were highlighted by HIQA inspections but also from reports of other clinicians who stated that the skill mix and consistency was not suitable for some residents. While inspectors acknowledge that recruitment procedures can take time there was no evidence that other interim strategies such as redeployment or changes to duties ad been made while awaiting recruitment.

The arrangements for quick access to emergency support for the volunteers were also not satisfactory despite the obvious commitment of a number of long-term co workers who lived on the campus. Staff described where they could not access this support on occasions and also where they were trying to deal with incidents of self-harm while also trying to access a phone.
The provision of training had been addressed with mandatory training in fire safety, manual handling, medication management and safeguarding up to date. A small number of new staff or volunteers who had not had this training were scheduled to do so within a reasonable time frame. However, the findings in relation to specific interventions such as behaviour supports or therapeutic interventions indicate that further guidance and oversight is required for staff.

The residents were assessed as not requiring fulltime nursing care but a nurse was employed to provide oversight and guidance to staff where needed.

Inspectors reviewed a sample of staff and volunteer files and found that all the required information such as evidence of Garda Síochána vetting was present. Volunteers had clearance.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

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Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003625
Date of Inspection:	15 and 16 November 2016
Date of response:	22 December 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not consistently outline the supports required to meet the residents' assessed needs.

1. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident

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

no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
The Centre is in the process of putting in place a formalised "Specific Health Management Plan" which will outline the supports required as identified in the Needs Assessments of each resident. These identified supports will be named in the Personal Plan and linked to relevant risk assessments. (copy of Specific Health Management Plan enclosed)

Proposed Timescale: 24/01/2017

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No multidisciplinary review of a personal plan was held during a period of crisis and to decide on changes to a resident's living arrangements.

2. Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
The Centre has now put in place quarterly reviews in addition to the annual review.
If an urgent review is deemed necessary as a result of behaviour that challenges, there will be immediate action which will involve multi-disciplinary team and family in order to agree the most appropriate course of action.

Proposed Timescale: 01/01/2017

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 for identifying and responding to risks and identified incidents were not satisfactory or timely.

These included but were not exclusive to:

Residents at risk of unauthorised absence
Risk to residents from unauthorised persons at night

Risks due to staffing and skill mix.
Medicines errors
Analysis of incidents.

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

Please state the actions you have taken or are planning to take:
• Where there is a risk of unauthorised absence identified, waking staff have been put in place. (Implemented)

• Locks have been installed on all doors of all residential houses in the Centre to remove the risk to residents from any unauthorised persons at night. (Implemented)

• An incident monitoring/analysis system has been introduced which will include a review of each incident/accident and medication errors to enable the Centre to identify patterns of behaviours that challenge to ensure the systems for learning and review of incidents is satisfactory. (Implemented)

• Additional Social Care staff (five) have already been employed and have begun work since the inspection.

• Further interviews will take place in the New Year for additional Social Care staff in relevant houses as needed. This increase of Social Care staff will balance the skill mix in the centre thus reducing risks including medicine errors. (Ongoing)

Proposed Timescale: 28/02/2017

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One fire door had been damaged which negated its function in containing smoke.

4. 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:
The fire door in question has been repaired

Proposed Timescale: Completed

Proposed Timescale: 22/12/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Systems to identify underlying causes and support residents behaviour and therapeutic needs were not implemented in a consistent and cohesive manner with adequate oversight.

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

Please state the actions you have taken or are planning to take:
Psychologist holds a clinic in Kyle on a regular basis for ongoing reviews for residents who present with behaviours that challenge.
An incident monitoring system has been introduced to review each incident and identify patterns of behaviour that challenges. This exercise is carried out on a weekly basis and all alternative measures to alleviate behaviours will be made before any restrictive procedure is considered.
Incidents that require urgent attention will be reviewed immediately.
Risk Assessments will be updated following any incidents if deemed necessary.

Proposed Timescale: Implemented

Proposed Timescale: 22/12/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not consistently demonstrate that they had the knowledge and skills to implement behaviour or therapeutic supports.

6. 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:
The centre will introduce an up-to-date behaviour support plan for each resident which will be linked to the personal plan. The centre will ensure that all staff will read, understand and sign off on these plans.
Behaviour support plan will be reviewed and updated in line with the any learning identified from the incident review/analysis

Proposed Timescale: 31/01/2017

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Five incidents of unauthorised of absences were not notified to the Chief inspector.

7. Action Required:
Under Regulation 31 (1) (e) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any unexplained absence of a resident from the designated centre.

Please state the actions you have taken or are planning to take:
All unauthorised absences will be notified to the Chief inspector within time frame as laid out in the regulations 31 (1) (e)

Proposed Timescale: Implemented

Proposed Timescale: 22/12/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge does not meet the requirements of the regulations.

8. Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
• The named Person in charge returned to post immediately after inspection
• Deputy Person in Charge was appointed directly after inspection
• Recruitment has taken place for a new Person in Charge and interviews will be carried out first week in Jan 2017. Post will be filled within a few weeks

Proposed Timescale: Implemented

Proposed Timescale: 22/12/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Managements systems did not provide oversight of the safety and quality of care in the following areas :

-Safeguarding systems for behaviour support and therapeutic intervention
-Risk assessment and response procedures
-Skill mix and deployment of staff .

9. 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:
1. The centre will introduce an up-to-date behaviour support plan for each resident which will be linked to the personal plan. The centre will ensure that all staff will read, understand and sign off on these plans.
Behaviour support plan will be reviewed and updated in line with the any learning identified from the incident review/analysis
2. The risk assessments are being updated and standard operating procedure forms will be introduced for any high risk identified. Risk assessments will be reviewed following any incident and updated if necessary.
3. Additional Social Care staff (five) have already been employed since the inspection and further interviews will take place in the New Year for additional Social Care staff in relevant houses as needed. This increase of Social Care staff will balance the skill mix in the centre thus reducing risks including medicine errors. (Ongoing)

Proposed Timescale: 31/01/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was dependence on volunteers to provide care and support in the absence of oversight and guidance by suitably qualified and experienced staff. Deployment arrangements were not satisfactory to support this

10. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and

skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
Additional Social Care staff (five) have already been employed since the inspection and further interviews will take place in the New Year for additional Social Care staff in relevant houses as needed. This increase of Social Care staff will balance the skill mix in the centre thus reducing risks including medicine errors. (Ongoing)

Proposed Timescale: 28/02/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Supervision systems were not consistently robust and suitable to enable staff to carry out their duties effectively.

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

Please state the actions you have taken or are planning to take:
Supervision will be carried out on a monthly basis with all staff and will be recorded and reviewed.

Proposed Timescale: 31/01/2017