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:	Janice Hyde
Lead inspector:	Noelene Dowling
Support inspector(s):	Liam Strahan
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 monitor ongoing regulatory compliance. 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:
26 September 2017 09:30	26 September 2017 19:30
27 September 2017 08:45	27 September 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 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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection was the final in a series of inspections to inform the registration of this centre. It was unannounced.

This was the fifth inspection of this centre which forms part of an organisation which has a number of designated centres nationwide. The registration inspection was undertaken on 19 April 2016. This necessitated an immediate action plan to be issued to the provider in relation to training in medicines management and the management of choking incidents. As result of the overall findings of that inspection a follow up inspection was required.

Unsolicited information received by HIQA triggered a further unannounced inspection on 22 August 2016. That inspection found further non compliances in safeguarding, implementation of crucial aspects of personal plans and also in staffing. A further follow up inspection took place in November 2016 which demonstrated a number of improvements but due to deficits in governance the registration could not proceed at that time.

A further inspection was undertaken in April 2017 and there were definitive

improvements noted at that time. This inspection was carried out to verify if the provider had put systems and structures in place to sustain improvements.

How we gathered our evidence:
Inspectors reviewed the 8 actions required from the inspection of April 2017 and found that five had been completed satisfactorily. Inspectors met with most residents and spoke with five residents. The residents communicated in their own way and allowed inspectors observe some of their daily life and routines in the centre. Residents told inspectors they were very happy living in the centre, things were good, they were looking forward to planned changes in their accommodation and enjoyed their activities.

Inspectors also met with staff members, the person who was holding the role of person in charge and the newly appointed regional manager. 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, with moderate intellectual disability, autism, behaviours that challenge and physical dependencies. The care practices and systems were congruent with the statement of purpose.

The centre 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 are suitable for purpose. These units also accommodate a number of co workers /volunteers.
On the days of the inspection there were 16 residents living in the centre.

Overall judgment of our findings:
Improvements seen at the previous inspection in April 2017 had not been sustained. The governance structures had altered significantly and were not stable or adequate to support a safe and consistently stable service for residents.

The findings of this inspection are influenced by the recent significant changes to the governance structures, changes in key personal in some of the units and the recent intake of a significant number of new volunteers. Findings in governance, staffing and safeguarding are a repeat of issues previously identified to the provider and indicate that the provider has failed to take effective and sustainable action to address these issues.

Issues identified which had a direct negative impact on residents included:
• lack of stable management, oversight and direction (Outcome 14)
• skill mix of staff, deployment and supervision of staff (Outcome 17)
• lack of consistent implementation of safeguarding systems (Outcome 7)

Some areas of good practice had been maintained and were observed in the following areas;• residents had good access to healthcare and multidisciplinary specialists and good personal planning systems were evident which supported their

well-being (outcome 5)
• behaviour support and clinical interventions were effective and showed a positive impact for residents.(outcome 8)
• medicine management systems were safe and were monitored (outcome 12)

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.

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):

Findings:
While this outcome was not reviewed in its entirety inspectors were satisfied residents' rights were respected and supported. Systems to ensure that issues identified at previous inspections ,such as mandatory rest hours or attendance at community events were left to residents preferences and own choice.

There was evidence that participation in the various day to day activities, workshops were also monitored to ensure residents were happy with these and where they communicated their dissatisfaction these were altered.

House meetings were held. The quality of these meetings differed however in how residents were encouraged to communicate or participate and what was open for discussion. However, there was evidence that key workers or house co-ordinators did individually seek to support residents and ensure their preferences were understood. Residents' families or next of kin were also consulted on their behalf as appropriate.

Residents maintained control of their own possessions and these were itemised. They had suitable locks on bedroom and bathroom doors to maintain their privacy but allow staff access if necessary.

The policy on the management of complaints was in accordance with requirements with nominated officers and evidence of oversight. No issues with regard to residents' rights had been raised since the previous inspection. Independent advocates and social work supports were also available for a number of residents.

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):

Findings:
There was evidence that residents' needs were being clinically assessed with good multidisciplinary access and review. These included physiotherapy, occupational therapy, speech and language, skin care and sensory assessments and dietary needs.

There were pertinent support plans for all needs identified including health care, personal care, falls risks social activities and sensory based programmes. There were clinical assessments for speech and language, dysphasia, fall risks and mental health. The outcomes were incorporated into the resident's daily care including strategies for choking risks, management of diabetes, skin integrity or decreased mobility and interpersonal interactions.

Implementation of resident plans were impacted upon by staffing level and capacity. For example, a number of staff had received training in implementing sensory support programmes. However, the majority of these persons had left the centre at the time of the inspection which impacted on the residents' access to this programme. Inspectors also found that it was not being implemented in the manner which was directed by the specialist. This is also detailed under Outcome 17 Workforce.

Formal annual and quarterly reviews were held and these were informed by the multidisciplinary assessments and interventions undertaken. The review records were very detailed and indicted that residents' lives were being reviewed and their own wishes supported. These reviews were attended by the residents themselves where they wished to participate, family members, and external clinicians where this was relevant.

There were plans made for the coming year. Activities and day services were undertaken for trial periods and a number of residents were seen to be participating in activities such as crafts and pottery which were new experiences for them. A number of

residents told inspectors about their plans and were obviously included in the progress made.

The social care and quality of life of residents was being well supported with good communication and liason between the various workshops and external day services which they attended.

There was a significant improvement noted in residents' access to external social events and locations and this necessitated a significant staff resource. More focused and meaningful activities outside of the campus had been implemented for some residents which could be seen to impact positively on their wellbeing. These included access to swimming, meals out and trips to various locations and art workshops.

Some residents, according to their preferences and abilities helped with cooking and worked on the land and with the animals as they wished. Staff were also seen to be supporting residents to develop important life skills Inspectors were satisfied that the assessed needs of the residents could be met within the centre.

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

Findings:
Inspectors found that overall arrangements were in place to ensure that the health and safety of residents, visitors and staff and this was balanced with residents' individual right to choose activities which involved risk. Policies and procedures were in place for risk management, emergency planning and health and safety. However, improvements were required in fire safety procedures.

A review of fire drill records indicated that many of the fire drills were as a result of false activations of the alarm, rather than planned drills for learning outcomes. Moreover there had been a large turnover of staff at the start of September 2017and there had been no drills since. Consequently many of the current staff had not had an opportunity to apply their fire safety training in a manner that confirmed their understanding of it.

The centre had adequate means of escape. Fire exits were unobstructed on the days of inspection. An external fire consultancy company had been engaged for the regular service, inspection and maintenance of the fire alarm, emergency lighting and fire safety

equipment. The most recent service had been undertaken in September 2017. Fire fighting equipment had been last serviced in March 2017. Internal checks were also routinely undertaken and recorded.

Procedures for the safe evacuation from the centre in the event of fire were prominently displayed. There was an evacuation plan developed for each resident.

Records were available to state that all staff had undertaken fire safety training within the last twelve months. However staff were unable to communicate to inspectors as to how that training applied within the house that they worked in.

The risk register was reviewed and contained all risks identified within Regulation 26, as well as risks associated with the activities and equipment in the centre. Risk registers for individual residents were pertinent to their identified needs. These registers were seen to be kept up to date. Mitigating actions in these registers were seen to inform practice proactively.

Arrangements for investigating and learning from incidents and near-incidents involving residents were also in place. These included a weekly review of accidents and incidents undertaken by the person in charge and the health and safety manager. Appropriate actions had been taken to follow up on incidents including holding staff meetings to communicate the evolving needs of residents, identification of triggers for incidents and reviews of measures to ensure that they were effective. One example was the identification of why one resident exhibited behaviours that challenge when in the company of a particular support worker. This allowed a greater identification of the types of support needed by this resident and facilitated improvement in their support plans.

All household cleaning agents and chemicals were seen to be stored in locked cabinets and alginate bags were available for any laundry and staff were able to inform inspectors as to how these were correctly used. Suitable laundry equipment was available.

An emergency plan was in place. This detailed the actions to be undertaken in the event that the centre had to be evacuated. It also included arrangements for alternative accommodation. Emergency phone numbers were accessible to staff.

The centre had access to a number of vehicles. Maintenance and service records indicated that vehicle roadworthiness was kept under review. Vehicles were also under regular inspection for the presence of road-safety equipment.

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:
Improvements were required in systems for devising robust safeguarding plans, ensuring that all issues were managed within a multidisciplinary framework inclusive of relevant agencies and ensuring that staff adhered to their professional reporting responsibilities.

A safeguarding plan which was seen by inspectors did not address the full range of risk and concerns presented by the resident and this created a vulnerability and further risk for the resident. There was evidence that concerns identified at the last inspection had been acknowledged by the previous person in charge and meetings with the appropriate agencies were requested .These meetings had not occurred however. Given the complexity of the situation it was crucial to ensure that decisions being made took all factors and information into account for the residents' safety and monitoring of the ongoing situation. The provider's response was not satisfactory to protect the resident.

The provider was aware of a number of situations where staff had acted inappropriately towards residents. Investigations were carried out and remedial actions taken by the previous person in charge. However, in some instances the actions were not sufficiently formalised or targeted to ensure staff understood their responsibilities. Sufficient steps were not taken to highlight to staff the seriousness of failing to report safeguarding concerns and to ensure that an accountable system was in place. For example, where two staff had failed to report a significant incident involving a colleague, the response was for all staff to receive training in the protection of vulnerable adults and for the safeguarding officer to received updated training. This response did not demonstrate that the provider could take definitive, effective and proportionate action to address these safeguarding concerns.

Most residents required support to manage their finances. While at unit level staff were vigilant and maintained detailed records the overarching monitoring systems was not sufficient. This was especially true where the provider was acting as agent for a resident .While no discrepancies were noted there were no agreed systems for oversight of this procedure. This had been raised at previous inspections yet the provider had failed to respond effectively.

There was evidence that residents' behaviours were supported by frequent clinical

review and oversight. The behaviour support plans seen by inspectors were detailed and in most cases followed and understood by staff . However, in one instance, the systems being implemented were not as identified in the support plan. The inspector saw however that this plan was effective, evidenced based and having a positive supportive impact on challenging behaviour and well-being.

A number of restrictive practices were used including some censors on doors which alerted staff but allowed residents freedom of movement. These were reviewed regularly and were seen to be the least restrictive,

Medicines were not used inappropriately to manage behaviours and in some instances the use of some medicines had been significantly reduced and were being carefully monitored by the prescribing clinician.

There were no children living on the campus at the time of 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):
No actions were required from the previous inspection.

Findings:
A review of the accident and incident logs, resident's records and notifications forwarded to the HIQA. Demonstrated that the person in charge was in compliance with requirement to forward the required notifications to the HIQA. All incidents were found to be reviewed effectively internally.

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 residents had a range of complex healthcare needs which the inspectors found were well supported and monitored. A local general practitioner (GP) was available to the residents. Records and interviews indicated that there was frequent, prompt and timely access to this service. Residents' health was also monitored by the part time nurse.

There was evidence from documents, interviews and observation that a range of allied health services were available and accessed promptly in accordance with the residents' needs. These included occupational therapy, physiotherapy, speech and language, neurology, psychiatric and psychological services. Chiropody, dentistry and ophthalmic reviews were also attended regularly.

Healthcare related treatments and interventions were detailed and staff were aware of how to implement these. These included dietary supports, skin integrity and mobility.

Suitable care plans were implemented and evidence based assessment tools were also used for example, for increased dependency and falls. Where [procedures were deemd to be overly traumatic or distressing for residents this was agreed with the family and the GP.
Inspectors saw evidence of health promotion and monitoring with regular tests, vaccinations and interventions to manage both routine health issues and specific issues. Staff were very knowledgeable on the residents and how to support them. Where necessary detailed daily records of, for example, dietary intake weights and skin integrity were maintained and reviewed by the part time nurse available.

Meals were prepared in each unit and systems had being implemented to ensure there was choice and variety especially for those residents who required modified foods. Pictorial images were used in some instances to help residents' make choices. Some residents used adapted crockery and cutlery to enable them to stay independent. Residents, staff and co workers shared all meals together and these were social and dignified experiences as observed.

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 policy on medicines management which was in accordance with legislation and guidance. Systems for the receipt of, management, administration, safe storage and accounting for all medicines was found to be satisfactory. Inspectors saw that there were appropriate documented procedures for the handling, disposal of and the return of medicines. A detailed medicines audit had been undertaken by the organisations nurse and actions identified had been addressed. However, staff were transcribing without dual oversight which presented a risk of error.

One error had occurred since the previous inspection .This was primarily due to the storage of other items in the medicines cabinet and also the fact that the volunteers were not using the safe storage systems provided for their personal medicines in the accommodation. The matter was however dealt with effectively.

There was evidence that medicines were reviewed regularly by both the residents' GP and the prescribing psychiatric service. There was data provided to staff to ensure they were familiar with the nature and purpose of the medicines and any medicines required to be administered in an altered format were adhered to.

In order to reduce the risk of errors an additional administration recording system had been implemented and the house coordinators audited the medicines regularly.

The healthcare assistants had training in medicines management and a number of staff also had specific training in the administration of emergency medicines. There were protocols in place for the administration of this medicine.

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:
There had been a deterioration in the governance structure since the previous inspection. Significant improvements were required both organisationally and locally to ensure oversight and clear lines of accountability were implemented.

The previous person in charge had resigned post prior to the inspection. While there was a new person appointed to the post since 01 August 2017, inspectors were informed this was an interim measure. It was not demonstrated that the person who was appointed to the post on the 01 August 2017 had the required qualifications and experience as prescribed by the Regulations.

This factor was further compounded by the local management arrangements whereby a number of house-co-ordinators had moved units or left post in the weeks preceding the inspection. In general there was a high degree of instability in the centre which was acknowledged by the staff.

The impact was evident in a lack of current knowledge on some residents care needs, progress and status.
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These changes occurred at a time when the majority of the volunteers who live in the units and form a significant part of the staffing compliment had left and a new group were arriving for the coming year which increased the instability. It was noted that despite this the local management and the staff group tried to minimise the disruption to residents. None the less, residents' records did indicate that these changes impacted on levels of anxiety for residents, behaviours in some instances, and a failure to implement plans which were essential to their well-being.

The provider advised HIQA that they intended to address this situation at organisational level by the appointment of a permanent person in charge and to augment the local management team with a further two deputy managers with defined responsibilities including the function of designated officer for safeguarding. However there was no clear plan for the implementation of this or if it would result in further changes within the centre. While some of these factors were outside of the providers direct control the timing of the changes of the volunteers was not.

A regional manger had been appointed directly prior to the inspection. Inspectors were informed that this manager's role would be to oversee the centre and support the person in charge

The system for the supervision of staff and volunteers was not effective. The supervision of staff, while now being undertaken regularly, did not demonstrate that professional conduct was being sufficiently addressed within this process. For example, where staff conduct had been a cause for concern these matters were not raised via the appropriate and formal medium of supervision. This approach did not support effective oversight and accountability. This matter was also identified in a "Trust in Care" safeguarding report completed on behalf of the provider. However, it was evident that the provider had failed to take effective action to address these identified concerns.

Systems commenced by the previous person in charge, including auditing of all untoward events or incidents continued and was seen to be effective and responsive to events. There was evidence of improved local management meetings which focused on resident care and support.

The provider had carried out the required two unannounced inspections to the centre to monitor quality and safety. The provider had also compiled an annual report which included the views and experiences of residents and families. While the report was detailed it lacked sufficient full oversight such as review of incidents, safeguarding matters, staffing issues to provide a comprehensive and transparent review of the quality and safety of care. As a result the provider did not demonstrate that they had meaningful oversight of the centre.

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):
No actions were required from the previous inspection.

Findings:
This provider's model of service is a combination of employed social care workers supplemented by a large number of volunteers who reside within the centre. A small number of these volunteers are long term, while the majority volunteer for approximately twelve months. The service also has ancillary staff including farming staff and craft-persons, as well as having some minimal nursing support.

Inspectors saw that there was pressure on the employed staff which number totalled twenty five. The volunteers could not undertake specific tasks and for instance, due to the changeover of volunteers there was a shortage of drivers to support residents' activities. In addition, where specific interventions such as sensory work was required for residents, all of the persons trained in this had left the centre at the time of this inspection. Access to this was therefore not readily available to the residents. Stability of core personal was referenced in a number of clinical assessments for the residents. The staffing arrangements did not support this.

Induction records reflected several shortcomings in induction training practices. Firstly

some critical elements of induction for the new volunteers were actually being undertaken by the volunteers who were leaving as opposed to the qualified permanent staff. This included the provision of intimate and personal care. Secondly, records reflected that at least some volunteers had not had their induction signed off for periods of up to 26 days after they commenced within the centre. The provider could not demonstrate if these were documentary deficits or if staff were actually given significant responsibilities for safety and care of residents prior to adequate induction and assessment of competence.

Concerns in regard to the supervision of staff are detailed under Outcome 14: Governance and Management.

The rosters indicated that there was a qualified person, if not in each unit, then on the campus at most times. Nonetheless , there was a need to review the deployment of the employed staff to ensure they met residents' assessed needs in a timely, accountable and appropriate manner. Rosters were unclear with regards to start and finishing times of staff.

A selection of staff files were reviewed over the course of the inspection and in the majority these contained the documents as required by Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. However, some shortcomings arose in situations where staff members moved between this providers various centres. In one example a staff member moved to this designated centre from another designated centre run by the provider. They were regarded as a new employee insofar as they entered a new period of probation and their supervision reports were not transferred with them. Yet that same employee was treated as having continuity of employment insofar as no new references were obtained. The effect of this is that neither supervision reports nor references were transferred with this employee causing the person in charge to have no knowledge as to if this employee had been satisfactory in their previous role. Such a lack of transfer of information exposed residents to potential risk.

This is further considered under records of staff training which were reviewed by inspectors. These records reflected that all staff had undertaken training in the lifting of persons and fire safety. While there were some gaps in training for medicines administration, crisis intervention and safeguarding these gaps had been identified by the provider and relevant training was scheduled within the short-term. These gaps were reflective of the recent intake of new volunteers. Staff also had accesses to additional training such as children's first, lámh sign-language, autism awareness, dysphasia, administration of epilepsy-rescue medicines, communication and other training relevant to the centre.

Judgment:
Non Compliant - Major

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

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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:	26 and 27 September 2017
Date of response:	2 November 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 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Residents' therapeutic programmes were impacted upon by the lack of consistent and suitably trained staff.

1. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the

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

assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A new Person in Charge commenced on the 31st of October, with each of the House coordinators she will review the personal plans of the residents, and audit for compliance of these plans.

The Newly appointed Person in charge will make contact with the Sensory support specialist by the end of November 2017, to review the sensory plans, and to organise training for identified permanent staff members. This will ensure continuity of care, there will be a schedule of review meetings but in place as deemed appropriate by the sensory specialist with the Person in Charge.

The person in charge along with the house coordinators will identity any gaps in training that is needed for staff and volunteers, to support the implementation of therapeutic programmes for the residents in the designated centre, to organise any training that is required in a timely manner

Each house coordinator will develop a schedule of staff supervision meetings, which will take place every 4 to 6 weeks for the staff working under her/his remit, or more often if required. Residents plans will be a set item on the agenda

The person in charge will develop a schedule of supervision meetings, with the deputy Person in charge and the house coordinators every 4 to 6 weeks , were personal plans/ residents welfare will be on the agenda.

The person In Charge and the PPIM meeting will have a Scheduled weekly welfare meeting and two residents will be identified for review at this meeting. This will allow for every resident to have a review every 8 to 10 weeks.

The Regional Manager will carry out supervision with the Person in charge every six weeks, and resident's programmes/ welfare will form part of the set agenda.

Proposed Timescale: 30/11/2017

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:
Since a large turnover of staff there had been no planned drills. Consequently staff had not been able to apply their fire-safety training and were unable to inform inspectors as to the appropriate response in the event of a fire.

2. Action Required:
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably

practicable, residents, are aware of the procedure to be followed in the case of fire.

Please state the actions you have taken or are planning to take:
The Person in charge with the coordinator of health & safety for the designated centre will set up a schedule of unannounced fire drills, including a night time fire drill, for all of the houses in the designated centre, to include the rest of 2017 and 2018.

The person in Charge and the house coordinator, will review each of the residents, individual fire evacuation plans, with each of the residents, and to ensure that they are written, in the communication style of the resident.

Health & Safety will be a set item on the agenda for the Management group of the Designated centre, were fire drills will be reviewed, risks will be identified and a plan will be drawn up to address these risks.

Review of Fire safety training will be undertaken to include practise and demonstration of learning by staff.

Health & safety is a set agenda item for discussion at the supervision meeting between the person in charge and the Regional Manager. The Regional manager will review fire drill practise as set out in line with the Scheduled fire drills.

Proposed Timescale: 30/11/2017

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider had failed to put effective systems in place to ensure residents were sufficiently protected in relation to safeguarding concerns.
The provider's response to abusive situations was not proportionate or sufficiently targeted.

Safeguarding plans and decision making frameworks were not robust.

Oversight of the management of residents' finances by the provider was not sufficient.

3. 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:
A Trust in care in report was commissioned at the time, and although carried out and recommendations actioned, it was not summited to the provider. The provider updated the tic policy prior inspection, 21/8/2017 to require a trust in care investigation team to submitted a report of its finding and recommendation to provider nominee, the people referred to in the above report have now left the organisation and the country. By the e

November 6th all PICs will be instructed that all staff failing to report an allegation of abuse will be subject to a disciplinary process.

Trusts in Care procedures have been fully updated. Review of the process undertaken and mandatory Trust in care training has been conducted for all PICs, and further training will be rolled out for staff

The Provider has reviewed and updated its current safeguarding policy, and improvements to oversight of the safeguarding process will mean all aspects of the safeguarding procedure will have oversight by the regional manager, including review of Behavioural support plans and risk assessments required.

Regional Manager will include safeguarding on the set agenda at their 6 weekly supervision meeting with the person in charge, to review concerns in line with Trust in Care policy

The provider has established a National safeguarding panel that will meet on a monthly basis to review safeguarding concerns, to identify any organisational learning, and to develop plans to address any identified risks for the organisation.

Safe guarding is a regular on the Providers Senior manager fortnightly meeting.

The directors CCOI have agreed to the establishment of a quality safety subcommittee of council

A 3 monthly Audit of the resident's finances and processes in the designated centre will be carried out by the regional manager.

Proposed Timescale: 31/12/2017

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:
The post of person in charge was not held by a suitably qualified and experienced person and was on an interim basis only.

4. 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:
A new Person in Charge has been appointed for the designated centre and commenced

on the 31st of October 2017. She is a highly experienced manager with the suitable qualifications and relevant work experience.

Proposed Timescale: 31/10/2017

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management structure was not robust or stable.

5. 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:
The Provider has met with the Person in charge to review staffing in the designated centre.

To ensure that there is a robust management structure within designated centre, They identified the need for two deputy persons in Charge, one will have a remit for safeguarding, complaints and be the Designated officer for the centre. They will work closely with the Person in charge in developing safeguarding plans, and summit these to the Regional Manager

The second deputy person in charge, will have a remit for care coordination with in the designated centre, this person will also take a lead, with the person In charge in developing advocacy practises in the designated centre. The care coordinator will develop rosters to ensure that there is the appropriate skill mix on each shift.

These post will be advertisied on the 2/11/2017, and we envision that they will be in post, by mid-January 2018.

Both deputy PICs will be a PPIM, and will attend the fortnightly management meetings.

Proposed Timescale: 30/01/2018

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Systems for the supervision and monitoring of staff were not sufficient to ensure duties of all personal were carried out safely and satisfactorily.

6. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
There will be a schedule of 4 to 6 weeks, supervision meeting set up, for the coming year for each staff member in the designated centre which will be carried out by their direct supervisor.

Review of the supervision template to ensure robust and effective oversight of the supervision process

A supervision schedule will be drawn up, by the Volunteer coordinator, in line with the Person in charge for the volunteers, in the designated centre

All annual reviews for all the providers designated centres will now be using the HIQA template going forward, to capture all relative areas including accident, incidents, safeguarding and staffing.

Proposed Timescale: 30/11/2017

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a failure to ensure continuity of staff who were appropriately equipped to provide care to residents.

7. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
The Regional Manager along with the Newly appointed person in charge will review the current training records of all staff, in the designated centre, and will develop a schedule of Mandatory training required for the coming year.

The regional manager and person in charge will develop and carry out a training needs analysis of all staff in the designated centre, which will identify priority areas of the training required and allow for the development of a CPD programme, for the staff in the designated centre.

Proposed Timescale: 31/01/2018

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was inadequate information on file in one of the sample staff files reviewed.

8. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
The newly appointed Person In Charge will audit all the personnel files for the information and documents specified in schedule 2 to ensure the designated centre is compliant

Proposed Timescale: 31/12/2017

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Induction and training for volunteers was not consistently provided by or overseen by persons with competence to do this.

9. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
The Regional Manager, Person in Charge and the Volunteer coordinator, will review the current induction and training provided to volunteer in the designated centre, seeking the current volunteers feedback, of the induction they received and identify gaps in that training.

A comprehensive Induction programme will be developed for volunteers in line with best practise identified from other designated centres with in the providers remit.

There will be an element of evidence based review, with the volunteer coordinator for each volunteer at the end of the induction process , to ensure that there is a transfer of learning in to everyday practise

Currently the provider is evaluating 3 IT Social care management system with the few of implementation in February / March 2018

Proposed Timescale: 30/04/2018