## Centre name:
- Camphill Community Duffcarrig

## Centre ID:
- OSV-0003610

## Centre county:
- Wexford

## Type of centre:
- Health Act 2004 Section 39 Assistance

## Registered provider:
- Camphill Communities of Ireland

## Lead inspector:
- Noelene Dowling

## Support inspector(s):
- Paul Pearson  Niall Whelton

## Type of inspection
- Unannounced

## Number of residents on the date of inspection:
- 24

## 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 Representation received This monitoring inspection was un-announced and took place over 2 day(s).

The inspection took place over the following dates and times

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

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Summary of findings from this inspection

This was the sixth inspection of this centre undertaken in order to make a final determination of the registration status.

The centre has had significant changes at local management level since the first inspection. This resulted in a lack of consistent governance and stability. Following the findings of the last monitoring inspection in July 2017, a number of formal meetings with HIQA and concerns regarding the capacity of the provider to operate a safe and well governed suitable service a notice of proposal to cancel and refuse the registration of the centre was issued by HIQA on 10 October 2017. The notice focused on governance and safeguarding for residents. As part of the regulatory process, the provider was given 28 days to respond to this notice and outline the actions they intended to take if they wished to continue the operation of the centre. A response was received and the Chief Inspector requested a further inspection to ascertain if these actions had been carried out and if they were effective.

How we gathered our evidence:

Inspectors met with 10 residents, a number of staff, and the person in charge,
deputy and regional manager. Practices were observed. Residents who could communicate told inspectors they felt very happy and safe living in the centre and where changes had been made for their care or accommodation they were very happy with these. They choose their own activities, daily routines or work, and could tell any staff if they had a problem. They said they had good access to medical care and social events and staff helped them to do these things.

Other residents allowed inspectors to observe some of her daily lives and communicated in the own preferred manner. Inspectors observed that they were relaxed in their interactions with staff, and staff were engaging very well with the residents.

Inspectors also met with family members who expressed their satisfaction with the care provided, and the changes in employed staffing levels, which would prove less disruptive and provide more continuity for the resident’s lives. Inspectors also reviewed documentation including resident’s personal plans, safeguarding plans, financial records, personnel files, supervision record, and management meeting records, audits and incident reports.

As the required fire safety works had not been completed at the inspection in July 2017 HIQAs fire safety specialist undertook a review of the premises based on the schedules of works supplied by the provider. There were some concerns identified which were discussed with the provider. The provider responded promptly to these by immediately supplying waking night staff in the units concerned and rectifying the problem. A further review by the fire authority was also arranged promptly. The findings of the specialist review and updated information are included in the health and safety section of this report.

Description of the service:

The statement of purpose states that the service is designed to provide long-term residential services for adults, both male and female with moderate intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviours. Fulltime nursing care is not provided or required by the residents. The service and care provided was congruent with this statement.

Service is provided to 25 residents in six residential units, accommodating between five and one resident and varying numbers of short-term volunteers who live in the units for agreed times.

The centre will therefore comprises 6 units.

The apartment was seen by inspectors and was suitable for purpose. Inspectors were advised that upgrading of fittings and furnishings will be undertaken in conjunction with the resident prior to this being occupied. The provider agreed to forward the necessary amended application information.

Summary of findings;
The actions required following the previous inspection, which took place in July 2017, were reviewed. Eleven actions were identified and satisfactory progress had been made on all of these. Moreover, the specific actions outlined by the provider in his response to the notice of proposal had also been completed with the exception of nursing oversight. This was however being addressed. Further improvement was also required in relation to fire safety, where satisfactory progress had not been made in line with plans submitted to HIQA.

Identified improvements focused on:
- local management and direct oversight arrangements
- additional employed staff
- systems for monitoring of practices and untoward events
- more robust and effective reporting arrangements
- additional training and supervision of staff and volunteers,
- a review of the role of the volunteers in the centre.
- systems for recognizing and responding appropriately to potentially abusive situations
- stronger quality review and oversight by the national management team.

It was acknowledged that significant work had been done and resources deployed to achieve this and it was seen to have beneficial effect on the residents' welfare and safety.

Good practice was identified in areas such as:
- access to meaningful recreation, activities and multidisciplinary assessments, which supported residents' quality of life (outcome 5)
- healthcare needs and medicines management, which ensured residents' safety and wellbeing (outcome 11 & 12)
- suitably qualified skill mix and numbers of staff and volunteers whose roles were clearly defined and overseen which promoted improved outcomes for residents (outcome 17)
- adherence to regulatory requirements to notify The Chief Inspector of significant and untoward events.

Some minor improvements were still required in the documentation used for medicines management and the signed agreement and fees for service to be provided.
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:
The actions from the previous inspection had been satisfactorily resolved. The person in charge had undertaken a review of all complaints made previously to ascertain the status and ensure they were satisfactorily completed.

A revised process had also been implemented whereby a local committee oversaw the management and resolution of complaints. Inspector saw that any issues that arose had been satisfactorily addressed and the staff was seen to actively encourage the residents to express their views on a number of issues.

Residents stated that they could freely tell staff if wished to make a complaint and matters would be addressed for them.

Advocates had been sourced for a number of individual residents to support them in making decisions and ensure their views were included in the process. Staff were actively advocating for residents about their changing needs for care and support within the centre. It was apparent that residents had choices in day-to-day activities and that routines were centred on their own preferences and wishes.

Changes to daily work and activities were made at their request. Staff were also currently reviewing the daily routines with residents and by observation to ascertain if they remained suitable or if the residents would enjoy other experiences. Throughout the inspection, staff members were seen engaging with residents in a respectful, caring and relaxed manner.

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

**Findings:**
The action from the previous inspection had been resolved in that all residents had contracts for services issued. However, addendums had been added detailing fees and other charges and these had not been signed for or on behalf of the residents where this was necessary. The charges detailed were satisfactory.

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

**Findings:**
The actions required from the previous inspection had been satisfactorily addressed. There was evidence that residents had access to frequent relevant assessments of need, suitable support plans were being implemented to the residents benefit and this process was now monitored. In this instance, staff had reviewed residents personal support plans and qualified key workers had been appointed to each resident. They were found
to be detailed and pertinent to the residents needs. This included the implementation of sensory supports or increased socialising at a pace suitable to the resident.

Introductions to other activities were being trialled with residents. It was apparent that the residents contributed to these plans in their preferred manner, with supports.

Meaningful and varied goals were also identified and completed for each resident. These included additional healthcare and social care needs. Plans were made to go to local recreational activities, the cinema and shopping locally on a regular basis. These goals were reviewed monthly to ensure they were being implemented. Annual and more frequent reviews took place attended by residents as they wished and or their representatives.

The reviews meetings were detailed, informed by the resident’s assessments, with changes made and goals revised. Resident’s accommodation was also being revised within the centre to ensure they best suited the resident’s needs and preferences.

Inspectors were satisfied that the centre could meet the needs of the residents and was continuing to plan for improvements in doing so.

Judgment:
Compliant

### Outcome 07: Health and Safety and Risk Management

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

#### Theme:
Effective Services

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

#### Findings:
Inspectors found that risk management processes and systems were in place but some risks remained. It was acknowledged that the fire safety works of concern were not due for completion until the end of March 2018 and considerable progress was being made in progressing this work. However, on review of the plans submitted and the works underway further concerns were noted which the provider was required to respond to.

Inspectors found that the action from the previous inspection with regard to the fire safety improvement plan was partially addressed. In addition to following up on the actions arising from the previous inspection the inspectors reviewed each building in the presence of the health and safety staff member. At the time of inspection, there were on-going improvement works taking place, which were nearing completion.
In the main, inspectors noted good practices with regard to fire safety. For example, the assessment of residents needs was well thought out and appropriately documented. There was a detailed questionnaire filled in for each resident with pertinent information extracted to a concise personal emergency evacuation plan. A weekly schedule was available which detailed staff and co workers duties in terms of evacuation for both day and night times. Inspectors reviewed a fire safety register for one of the residential units. This was found to be sufficiently detailed and kept up to date. Staff spoken with were found to be knowledgeable with regard to the evacuation procedures in place in the centre.

The designated centre consisted of six residential buildings, spread out on one large rural site. In July 2017, HIQA received reports detailing upgrade works to five of the six buildings. Inspectors found significant progress had been made with respect to the implementation of the fire safety upgrade works. However, inspectors were issued with updated Fire Safety Risk Assessment reports for four of the buildings. Some work identified in the original reports did not appear to be carried out and were not referenced in the updated reports. Therefore, previously recommended works were omitted without a rationale. For example, there were a number of instances where the recommended remedial work included continuing fire rated partitions up through the attic to roof level to prevent the spread of fire. This work was not carried out. To this end, inspectors found that each residential unit required further review by a competent person to determine any outstanding remedial works.

In general, fire doors had been fitted in the centre to improve means of escape and provide containment of fire. Fire doors were found to be well fitted and would be capable of containing fire in most cases. However, some doors required further remedial works to ensure they would be capable of restricting the spread of fire and smoke. Inspectors were informed that a snag list had been generated and the remedial works would be complete by the end of March 2018.

One of the residential buildings was not included in the schedule of proposed fire safety upgrading works and inspectors identified fire safety deficiencies in terms of containment of fire. There were a number of rooms which were not fitted with fire rated doors to prevent the spread of fire and smoke to escape routes. For example, the laundry room, cloak room and larder all formed one enclosure. This area was not adequately separated from the adjoining stairway, nor was the office, store room, bedroom and lounge. Although an alternative means of escape via an external stairway was available from the upper floor, inspectors identified a risk to a resident at ground floor whose bedroom was accessed directly off the stairway enclosure. This resident would be required to escape through the stairway enclosure at ground floor. If a fire occurred in a room adjacent to the stairway, this resident would not be afforded an adequate means of escape. This was brought to the immediate attention of the provider nominee and person in charge, who decided to place a waking co worker in the house until such time as the situation was satisfactorily resolved.

Where there were residents with hearing impairments, inspectors identified one instance where assistive equipment to alert a resident of a fire was not working. Inspectors also noted that access to the bedroom for this resident was through a stairway enclosure which contained two bedrooms at upper floor level, neither of which were fitted with fire
rated doors. This had been a recommendation in the latest fire safety risk assessment for the building. There was an external door to the room, but although there was a thumb turn fastening on the escape side of the door, staff were unable to open the door from the outside. In the event of a fire occurring in the building, staff would be unable to alert the resident that there was a fire. This was brought to the immediate attention of the provider nominee and person in charge, who committed to ensuring that there was a co worker awake in the house during night time until such time as the situation was satisfactorily resolved. By the second day of inspection, additional measures were put in place to ensure the resident would be alerted to the activation of the fire detection and alarm system.

In one residential unit, there were two bedrooms accommodating co workers at attic level. Access to these bedrooms was via a narrow spiral stairway. Inspectors were not satisfied that the means of escape from these bedrooms was adequate and as such would not be suitable for use for sleeping accommodation. This was brought to the immediate attention of the provider nominee and person in charge.

Escape routes were well maintained and clear of obstruction. However, some external routes led through grass areas and inspectors were not satisfied that the surface was suitable for escape.

Inspectors noted that the ceiling throughout one of the residential units consisted of timber sheeting. It was not clear if the timber sheeting was adequately treated to prevent the surface spread of fire. Inspectors found that this required review.

While there was significant improvement in the centre with regard to containment of fire, inspectors observed examples of breaches of fire resisting construction where service pipes and wires penetrated the enclosure but were not adequately sealed to prevent the spread of fire and smoke to adjoining spaces. There were a number of small linen stores on escape routes which were not provided with fire doors or smoke detection. Inspectors found this required review.

Inspectors noted that the centre was provided with emergency lighting, fire fighting equipment and a fire detection and alarm system throughout. Records showed that the fire fighting equipment, emergency lighting and fire detection and alarm system was being serviced at the appropriate intervals. Inspectors identified that emergency lighting was not provided externally in some instances.

To this end the provider requested a review by the fire safety consultant and the statutory fire officer. Details of this confirmed inspectors' findings and an action plan specific to this is to be forwarded to HIQA. In the interim the provider has committed to maintaining the additional waking staff levels where this is necessary.

The provider had made necessary arrangements for fire safety training to be provided to staff. Documentation available to inspectors demonstrated that training was up to date for all staff and co workers. It was explained to inspectors that fire safety training occurs monthly. When new staff or co workers commence working at the centre, they receive orientation in terms of fire safety procedures and will attend formal fire safety training within a month of their start date.
Two areas of further risk in the premises were noted. One was an open climbable balustrade over a void and windows which opened directly across the ramped access. No accidents had occurred as a result of these but they did require risk assessment.

In other respects inspectors saw individual and pertinent risk assessments and support plans, which had been devised for residents. These were detailed and gave appropriate guidance to staff to manage identified risks and take preventative actions. Where required, falls assessments and transporting plans were available and staff were familiar with these plans. Personal and pertinent evacuation plans were also devised. Staff had received appropriate training in fire evacuation procedures.

The quarterly and annual servicing certificates for the fire alarm system and emergency lighting were in place. There fire equipment had received its annual service.

However, inspectors identified an incident where a resident received a minor injury that required first aid while partaking in work activities. Additional control measures were recommended but these had not been incorporated into the residents risk assessment. This was rectified promptly during the inspection.

Inspectors reviewed the accident and incident register. Records of each incident occurring in the centre were maintained. These were risk rated and reviewed to ensure any additional control measure was put in place and these were monitored. These reviews and actions taken provided satisfactory systems for learning from untoward events including medicines errors. Recent adverse weather conditions had been planned for and managed well given the location of the centre.

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

Findings:
Inspectors were assured that the significant failings identified previously in the recognition of potently abusive interactions, adequate responses to such incidents, and
systems to monitor and prevent such occurrences had been initiated.

Following the last inspection, a full review of a number of potential safeguarding matters relating to staff or volunteers actions had been undertaken with appropriate investigations commenced. Appropriate actions were taken by the provider in response to the findings of these, which included additional supervision and monitoring for staff where this was necessary.

Additional training for staff in both safeguarding, and more focused training on the support of residents with behaviours that challenge was evident. This training was continuing with ongoing advisory support to staff. Two additional designated officers for safeguarding were appointed and training had been provided in the carrying out of investigations of this nature.

Individual psychological support for residents had also been sourced to good effect. Practices in the units including behaviour support and day-to-day care was carefully monitored by the deputy manager and this system was seen to be effective.

The actions required following the internal safeguarding review of 2017 had been addressed with one outstanding but this was scheduled to take place. All incidents were found to be reported, reviewed locally with actions agreed and overseen by the regional manager.

The increase in the number of trained staff also ensured that the work of the young volunteer / co-workers was supported and monitored. Revised codes of conduct for the volunteers in all of the communities following incidents of inappropriate conduct in other of the organisations centres had been implemented in this centre.

The inspector found that there was greater understanding of and a more timely response to any issues of safeguarding including peer-to-peer incidents or allegations made.

Changes had been made to resident’s accommodation to facilitate safeguarding systems and behaviour supports where this was necessary.

Restrictive practices were minimal and primarily safety related where they were used. Medicines were not used inappropriately to manage behaviours and the use was guided by strict protocols.

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:**
Residents’ healthcare needs, including nutritional needs, were identified and monitored with good access to appropriate medical and allied healthcare services. Regular medical and medicines reviews were evident.

In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists, physiotherapy, neurology, dentists and chiropodists and age and gender specific related services. Suitable support plans were available for all identified needs including skin integrity, dietary needs and falls risks. Staff were able to outline these to the inspectors.

There was evidence and residents confirmed that they and their representatives were consulted about, well informed and involved in the meeting of their own health and medical needs in as much as possible.

**Judgment:**
Compliant

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**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:**
The action from the previous inspection involved the details in the protocols for the use of emergency or PRN (administered as required medicines. This had been resolved. Systems for the administration, receipt of, storage and return of medicines were safe. However, the non-nursing staff were transcribing medicines and the systems for recording the administration of emergency medicines was cumbersome. While no errors had arisen because of this it may pose an unnecessary risk to residents.

**Judgment:**
Substantially Compliant

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The statement of purpose had been forwarded to HIQA and duly revised to reflect the changes to the governance structures and the accommodation in the centre. Admissions to the centre and care practices as seen were congruent with the statement of purpose.

**Judgment:**
Compliant

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**Outcome 14: Governance and Management**
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

**Theme:**
Leadership, Governance and Management

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

**Findings:**
All actions required from the previous inspection and all but one action detailed in the response to the notice of proposal in relation to management systems had been satisfactorily addressed by the provider. There was evidence that this had a positive impact on the resident’s wellbeing and safety. The employment of nurse for clinical oversight was ongoing with evidence of the provider’s actions to source this support. However, efforts were continuing to source this and inspectors were satisfied that currently this was not detrimental to residents.

There had been a significant effort made to achieve compliance with significant and effective changes to the level of oversight, monitoring of practices and supervision. The person in charge is suitably experienced and qualified and had been appointed following the previous inspection. In addition to this, two suitably experienced deputy managers had been appointed. One of these had specific responsibility for direct care
and oversight or practice in each unit.

There was a duty management presence on the campus at all times and systems of unannounced spot checks were introduced. All units had a qualified social care coordinator and deputy co-ordinators. Arrangements for deployment of staff ensured employed staff was available at crucial times for the more vulnerable or high support residents.

The role of regional manager had been implemented and this provided an increased level of management in the centre. This significantly increased the level of support and oversight to the person in charge.

There were formal, effective and timely reporting and response systems evident at all levels. These included data and analysis of accidents and incidents, safeguarding issues, and residents’ general welfare and wellbeing.

Formal staff supervision systems were implemented and adhered to. The content focused on resident’s care and staff development to provide this care. Staff and residents commented positively on these improved systems.

**Judgment:**
Compliant

**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:**
There were significant improvements in the staffing levels and support available to the residents with up to five additional qualified personal employed.

Deployment arrangements were made according to the support needs of the residents. A number of residents were supported by employed staff only and a number had two-to-one or one-to—one supports. Where necessary waking night staff were also available. There were effective systems for oversight and support of both staff and volunteers.

Inspectors found that the numbers and skill mix in this instance was satisfactory and the findings of the inspection are reflective of this change to the staffing structure. The
duties of the volunteers had been revised to be a more suitable reflection of the role, experience and level of responsibility. In addition, the intake of the volunteers had been staggered to minimise the disruption to the residents. At this inspection a member of the management team was assigned to oversee the recruitment and suitability of the volunteer intake which was more suitable and safe arrangement.

Inspectors reviewed a sample of staff files and found that while most files contained the required documentation as per Schedule 2 there were some small gaps in employment histories that were unaccounted for and copies of formal qualifications were not on file in some staff records. All staff files reviewed had Garda vetting and police clearance from other jurisdictions as required.

It was demonstrated that the supervision of staff, regular meetings and oversight structures supported improvements in practice and accountability amongst staff in the centre. All mandatory training had been undertaken with updates scheduled. / The training provided staff with the required skills to effectively support residents in the centre.

Inspectors spoke with staff during the inspection. They found that staff had the required knowledge and skills to support the residents in their daily lives and the volunteers were able to communicate effectively with the residents. Staff were knowledgeable regarding the resident’s needs and preferences.

**Judgment:**
Compliant

**Closing the Visit**

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

**Acknowledgements**

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

**Report Compiled by:**

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by Camphill Communities of Ireland</th>
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<td>Centre ID:</td>
<td>OSV-0003610</td>
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<tr>
<td>Date of Inspection:</td>
<td>13 March 2018</td>
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<td>23 April 2018</td>
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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 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Addendums had been added detailing fees and other charges and these had not been signed for or on behalf of the residents where this was necessary.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:

All resident’s financial support assessments will be reviewed and where appropriate support will be provided to service users to develop their capacity to manage their finances. SAGE advocacy service are currently reviewing the template currently used for service user contracts including schedule of fees. SAGE to provide support and guidance in respect of supporting service users to sign any documentation relating to their contract and schedule of fees. In cases where the person does not have capacity to consent to ‘terms of residence’ and fees applying resident’s will be supported to make a referral to an independent advocate and/or where appropriate their next of kin/or other identified and duly appointed representative can sign contracts on their behalf.

Proposed Timescale: 31/07/2018

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

Some risks had not been identified including open balustrades and windows which opened directly onto the ramped access route.

2. 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:

Health and safety audit to take place on the 19th of April 2018 by an external consultant- this point has been brought to the attention of the external auditor who will support the provider / PiC to identify other areas of potential risk.

Risks identified within the HIQA report to be addressed by the Community maintenance team - window restrictors to be fitted and open balustrades addressed and filled. In the interim risk assessments have been developed to reduce risk.

Accidents and incidents are reviewed at weekly management meetings. Risk assessments are revised and follow through actions taken. Additional dedicated H&S time has been allocated to the safety officer role to ensure implementation of actions. All accident and incident occurrences are now notified by the PIC to the Regional Manager in the service ‘weekly checklist’.

Proposed Timescale: 31/05/2018

Theme: Effective Services

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

Although significant progress had been made with respect to the implementation of the
fire safety upgrade works, some improvement works did not appear to be carried out and were not referenced in the updated reports. Therefore, previously recommended works were omitted without a rationale for their exclusion.

3. Action Required:
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.

Please state the actions you have taken or are planning to take:
Engineer to update risk assessments for fire upgrade works detailing the changes to previous schedule of works. Engineer to provide a cover letter detailing the rationale for the modifications to the original schedule of works ensuring it is in line with current relevant legislation and guidelines.

Cover letter from consultant engineer outlining rationale for revised actions and the associated risk assessment documentation for each location completed

Proposed Timescale: 23/04/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Inspectors identified a risk to a resident who was required to evacuate through a stairway enclosure which was not adequately separated from adjoining areas with fire rated construction.

In one residential unit, there were two bedrooms accommodating co workers at attic level. Access to these bedrooms was via a narrow spiral stairway. Inspectors were not satisfied that the means of escape from these bedrooms was adequate and as such would not be suitable for use for sleeping accommodation.

Inspectors noted that the ceiling throughout one of the residential units consisted of timber sheeting. It was not demonstrated if the timber sheeting was adequately treated to prevent the surface spread of fire.

Inspectors identified that emergency lighting was not provided externally in some instances.

Some external routes led through grass areas and inspectors were not satisfied that the surface was suitable for escape

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

Please state the actions you have taken or are planning to take:
Where a resident was required to evacuate through a stairway enclosure seven FD30S Fire doors have been installed, to effectively compartmentalize the adjoining areas and
to provide a safe escape route for the resident, this action was completed by 30-03-18

The rooms at attic level are no longer in use for sleeping accommodation.

Timber sheeting is to be removed or painted with intermission paint 20th June.

Pathways from external escape routes will be covered with a gravel and lead onto concrete paths to provide a safe means of escape September-2018

Emergency lighting will be installed to external escape routes to fire assembly points - July 2018

**Proposed Timescale:** 28/09/2018

**Theme:** Effective Services

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

Some fire doors required further remedial works to ensure they would be capable of restricting the spread of fire and smoke.

One of the residential buildings was not included in the schedule of proposed fire safety upgrading works and inspectors identified fire safety deficiencies in terms of containment of fire including a number of rooms which were not fitted with fire rated doors to prevent the spread of fire and smoke to escape routes.

Inspectors observed examples of breaches of fire resisting construction where service pipes and wires penetrated the fire rated enclosure and were not adequately sealed to prevent the spread of fire and smoke to adjoining spaces.

5. **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:**

Additional remedial works to existing fire doors has been completed by the maintenance team. Complete

Snag list completed by consultant engineer for all fire doors. Works to be completed by local maintenance team and reviewed by engineer upon completion

Risk assessment for house not included in proposed schedule of fire upgrades completed. L1 fire alarm system currently being installed in this property (this was due for completion-delays while ordering parts for upgrades). Seven fire doors have been installed to compartmentalize the adjoining areas. Other works identified with the engineers risk assessment are underway.

‘Firestopping’: All holes created from the installation of pipes and wires have been adequately sealed to prevent smoke and fire spread. Complete
Proposed Timescale: 30/06/2018
Theme: Effective Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Where there were residents with hearing impairments, inspectors identified one instance where assistive equipment to alert a resident of a fire was not working.

6. Action Required:
Under Regulation 28 (3) (b) you are required to: Make adequate arrangements for giving warning of fires.

Please state the actions you have taken or are planning to take:
Immediately following the inspection a waking night systems was in place to ensure safe evacuation if required while appropriate equipment was being sourced.

A sounder beacon with strobe light has been installed in the resident’s room. A new assisted alert pillow alarm has been installed. It vibrates when the alarm system is activated.

Proposed Timescale: 23/04/2018

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<th>Outcome 12. Medication Management</th>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The non-nursing staff were transcribing medicines and the systems for recording the administration of emergency medicines was cumbersome and had the potential for error.

7. Action Required:
Under Regulation 29 (2) you are required to: Facilitate a pharmacist in meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland and provide appropriate support for the resident if required, in his/her dealings with the pharmacist.

Please state the actions you have taken or are planning to take:
Pharmacist to transcribe all Kardex’s as required. Review of current systems for the recording and administration of emergency medications is in train in conjunction with the pharmacist and the local GP. The revised system will be rolled out and introduced in all instances where emergency medications are prescribed.

Proposed Timescale: 29/06/2018