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:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	ORG-0011520
Centre county:	Dublin 14
Email address:	adrienne.smith@camphill.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Person in charge:	Claudia Brave
Lead inspector:	Linda Moore
Support inspector(s):	Helen Lindsey;
Type of inspection	Announced
Number of residents on the date of inspection:	6
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 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 announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
25 March 2014 11:00	25 March 2014 19:30

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

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 was an announced inspection of Camphill Communities of Ireland- Greenacres to monitor compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013. Camphill Communities of Ireland- Greenacres comprises of three community houses where six people currently reside. There is currently one bedroom which is available for respite use, this was not in use of the day of the inspection. While the inspection took place over one day, inspectors provided feedback on the 26 March 2014.

Inspectors met with management, residents and staff members over the inspection. Inspectors observed practice and reviewed documentation such as personal care plans, medical records, accident and incident records, meeting minutes, policies and procedures, staff training records and staff files.

Overall, inspectors found that residents received a good quality service in the centre whereby staff supported and encouraged them to participate in the running of the house and to make choices about their lives. Resident's independence was promoted. There were regular meetings for residents, and residents' communication support needs were met very effectively. Inspectors found that the residents were comfortable and confident in telling the inspectors about their home. Residents were actively involved in the development of their personal plans.

While evidence of good practice was found, a considerable number of areas of non compliance with the Regulations were identified. Inspectors had concerns about some protection issues and an immediate action plan was issued to the provider following the inspection.

Areas for improvement included the governance arrangements, medication management, risk management practices, and access to training. The non compliances are discussed in the body of the report and included in the action plan at the end of this report.

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

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

Judgement:
Non Compliant - Moderate

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

Findings:
In general, inspectors found that residents were supported to be involved in the development of their personal plans. However, some improvements were required to ensure personal plans were based on the assessed needs of residents and outline the supports required to maximise the residents personal development in accordance with his or her wishes.

Each resident had a personal plan and inspectors reviewed three of the plans with a staff member. They were not based on the individual support needs of the resident and there was no documentary evidence of regular reviews. The personal plans were not multidisciplinary and there was no system to assess the effectiveness of the plans. The person in charge did not ensure that the designated centre was suitable for the purposes of meeting the needs of residents, for example two residents lived in a community house that was also used as a day service. These residents did not have full access to their living space during the day. Inspectors noted that day attendee's also

used the residents personal bathroom at times during the day.

The personal plans contained important information such as details of family members and other people who are important in their lives, wishes and aspirations and information regarding residents' interests. There were no assessments of resident's specific social, emotional, participation needs, preferences and preferred routines. There was no evidence of individualised risk assessments in place to ensure continued safety of residents. These had not been completed for residents who remained alone in the centre at times or travelled alone.

Each resident had opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. Residents attended day services outside the centre. Inspectors found that residents were supported to develop and maintain personal relationships and links with the wider community and that family were encouraged and welcomed to be involved in the lives of residents.

Residents told inspectors that family members and friends could visit at any time and some residents said that they visited their family home regularly.

Residents gave numerous examples of how they were involved in the running of the centre for example preparing meals and doing laundry duties and assisting to keep their bedrooms clean. There were weekly meetings where residents made decisions and asked staff for support.

Residents could make choices about their daily lives such as when to go to bed, what food to eat and how to spend their free time. Staff were observed interacting with residents in a respectful manner, consulting with them and seeking their views.

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

Theme:
Effective Services

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors generally found that the provider had put some risk management measures in place however a number of areas of improvement were identified, these included the risks associated with fire safety, and emergency planning, and, the systems for the identification, assessment, management, recording and investigation of risk.

Inspectors read the Health and Safety Statement for 2014. This document was not centre specific and did not include risk assessments of the environment and work practices in the centre. The person in charge and staff explained how they took responsibility for the identification of risks and ensuring that there were appropriate systems in place to manage risk. However, inspectors were not entirely satisfied that staff took a proactive role in the management of all risk in the centre. There were no risk assessments completed. The staff told inspectors they were not sufficiently trained in risk assessment.

There was a risk management strategy in place, however; there was no risk management policy as required in the Regulations. The strategy had not been localised and did not include the specific risks required by the Regulations including self harm, aggression and violence and the arrangements for identification, recording, investigation and learning from serious incidents. While there was a policy on resident absent without leave, this was not being used to guide practice. There was no individual safety plan or positive behaviour support plans for residents as outlined in the policy.

A small number of accident and incidents for 2014 were being recorded in detail and these were reviewed by the person in charge. Incidents were being discussed at the staff management meetings and were reported to the board meeting on a quarterly basis with a view to learning from them and reducing the risk of recurrence. However, this process was not robust or clearly defined in the policy and the learning was not documented. The risk register had not been implemented as yet.

Residents commented that they felt the centre was safe and secure because they had access to the person in charge or the social care leader as needed.

Inspectors found that while there was an emergency policy in place and alternative accommodation arrangements were discussed with inspectors, these were not set out in the policy.

Fire safety was generally well managed apart from fire safety training and learning from drills. There was evidence of regular fire drills and both staff and residents participated. The records of fire drills were detailed and included learning outcomes. However, while the learning was regularly documented; there was no evidence that these issues were addressed. Residents and staff were able to tell the inspector about what they would do if the fire alarm went off. Records reviewed by inspectors indicated that fire training had not been provided to all staff and the fire training only included the use of the fire extinguishers. The person in charge had not received fire training.

There was evidence that some of the fire safety equipment was serviced regularly, this included the fire alarms. However there were insufficient records to demonstrate that all equipment was serviced. Inspectors found that all fire exits were unobstructed on the days of inspection. There was no emergency lighting and there were only domestic smoke detectors in two of the houses, while the person in charge explained the arrangements in place, there was no risk assessment completed to identify if emergency lighting or smoke detectors was necessary and if the control measures were adequate.

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

Judgement:
Non Compliant - Major

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

Findings:
Inspectors found that there were insufficient arrangements in place to safeguard residents and protect them from the risk of abuse. There were areas for improvement in relation to the protection of all residents, staff training, the safe guarding policy and the systems to investigate all incidents.

Staff generally were knowledgeable about what constituted abuse but they were not knowledgeable about how they would respond to any suspicions of abuse. Inspectors found that all staff had received training on the protection of vulnerable adults however the person in charge who delivered the training was not sufficiently knowledgeable and had not been trained as a trainer in the area of protection.

There was a policy on adult and child protection in place, however it would not guide staff on how to respond to suspicions of abuse in accordance with the Regulations and it was not specific on how to safeguard all vulnerable individuals living in the designated centre. The provider was required to take immediate action to protect all residents in the centre.

Inspectors found that the person in charge had not implemented an investigation in relation to two incidents, allegations or suspicions of abuse and there was no incident report completed for these incidents. While there was some record in the management meeting of discussions in relation to one of these incidents, there were no records to show that appropriate action had been taken to respond to these allegations. The person in charge was required to take immediate action to respond to these issues. The Authority had not been notified of any allegation, suspected or confirmed abuse of any resident.

Throughout the inspection, inspectors noted that staff interacted with residents in a kind, caring, respectful and patient manner.

Residents confirmed that they felt safe and described the staff as being very caring and were able to tell the inspector about a number of staff whom they could talk to if they had a concern.

There were no restrictive practices in use in the centre at the time of the inspection. Staff had been provided with training in this area should resident's conditions change. Residents had access to psychology services, however behaviour support plans were not up to date or available to staff to guide practice. The policy was not being used to guide practice.

At the time of inspection there was no policy in place to provide guidance to staff on the care of residents' property and finances, as required by the Regulations. Residents showed inspectors how their personal finances were managed and a safe was provided.

The staff showed inspectors how some residents were using the balance of their disability allowance each week. Inspectors reviewed a number of these and noted transactions were being signed by a staff member and countersigned by the resident.

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

Judgement:
Non Compliant - Moderate

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

Findings:
Practice in relation to notifications of incidents was not satisfactory.

The person in charge was not aware of the legal requirement to notify the Chief Inspector regarding any allegation, suspected or confirmed abuse of any resident. To date and to the knowledge of inspectors, all relevant incidents had not been notified to the Chief Inspector by the person in Charge. The Authority had not been notified of any allegation, suspected or confirmed abuse of any resident.

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors found that there were appropriate arrangements in place to support residents' health care issues as they arose. Inspectors reviewed the care plans for residents and found that they had access to a general practitioner, including an out of hour's service. Staff said that residents accessed other health professionals such as the physiotherapy, dietician and speech and language therapist services if required.

There was some information on resident's health contained within the personal plans, However, these assessments did not include all aspects of the care required and there were no plans in place to address the areas identified. There was no risk assessment for a resident with epilepsy and no plan to guide care.

Inspectors were satisfied that residents received a nutritious and varied diet that offered choice and mealtimes were unhurried social occasions that provided opportunities for residents to interact with each other and staff.

Inspectors observed two dining experiences and joined residents and staff for refreshments in two of the three houses. Inspectors observed that the meal was well presented.

Inspectors found that there was an ample supply of fresh and frozen food, and residents could make themselves a snack at any time. Many of the residents told inspectors what they were making for their own lunch on the day of the inspection. Residents were supported to shop for the food for the houses and they made decisions on what they wanted to eat during the week.

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors found that the provider had put arrangements in place to support the person in charge in protecting residents in relation to medication management, however inspectors found there were some aspects of medication management including the safe administration of medication, and the competency of staff administering medication that required improvement.

The provider had developed a policy on the management of medication. This policy did not guide practice, for example crushing and PRN (as required medication) and the practice of self administering medications was not in line with the policy. Inspectors found that staff had not received medication management training which contravened the policy and staff told inspectors they were not competent to administer medications.

There was no up to date medication prescription for one resident with regards to a PRN (as required medication). The signage of the administration of medication required improvement. For example, there were gaps in the administration records. Staff said they administered over the counter medication as required without a prescription and there was no record that this was prescribed or administered. There was no photographic identification in place for any resident.

All resident self administered their medication with support, while there was an assessment in place, there was no evidence of a plan of care to guide this practice and the assessments had not been reviewed regularly in line with the policy.

While there was a weekly check of the medication completed, there was no system in place for reviewing and monitoring safe medication management practices.

There was no medication management protocol in place for residents who may experience status epilepticus.

Staff and residents had access to the pharmacists, who provided support to staff on the new medication if required.

When these issues were raised with the person in charge and provider, she informed inspectors she was going to arrange medication management for all staff immediately following the inspection.

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

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors found that the management systems in place did not ensure that services provided are safe, appropriate to residents needs, consistent and effectively monitored. The roles of managers and staff were not clearly set out and understood. Inspectors found that while there was a person in charge of the centre, she was not sufficiently knowledgeable of her statutory responsibilities.

The person in charge said she was supported by a social care worker and the provider nominee who reports to Board of Directors. The board met monthly. The minutes were reviewed by inspectors. However inspectors found that the provider did not give sufficient support to meet the needs of residents in the areas of psychology and Social work. Please see outcome eight regarding safeguarding and residents with behaviours that challenge.

The person in charge also holds weekly staff meetings with all staff to discuss any issues that arise. The person in charge collected quarterly data and reported this to the board. The person in charge said she met the provider six weekly but there were no minutes.

There was no system in place to ensure that staff exercise their personal and professional responsibility for the quality and safety of the services they are delivering. Inspectors found that the roles of the co- workers were not clearly defined, there were no job descriptions in place for these staff members and as they had not read the personal plans of the residents as they were stored off site, the plans did not guide the care delivered. There was no system in place to determine resident's needs or who was responsible to ensure needs were met.

The person in charge had worked in the Camphill Communities for many years; she was also in the process of continuing her professional development. She told inspectors she had received training on the requirements of the Regulations and Standards and was actively trying to update her knowledge. However, inspectors found that the person in charge was not sufficiently knowledgeable of her statutory responsibilities. While her role was full time she did not engage in the governance of the centre on a consistent basis. Inspectors found that there were a number of non compliances in the responsibilities of the person in charge, these included development and review of personal plans, medication management practices, staff training, behavioural support and protection; these issues are discussed throughout this report. There were appropriate deputising arrangements in place for the person in charge. The social care worker deputised in her absence.

There was a system in place to review the quality and safety of care in the designated centre. This includes external audits of the health and safety of the service.

Inspectors observed that she had a person-centred approach with residents and staff through her open and friendly interaction with them. She demonstrated strong leadership and good communication with her team. She was frequently observed meeting with residents and staff and ensured good support to all staff.

Documentation requested by inspectors was made available during the inspection.

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

Judgement:
Non Compliant - Moderate

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

Findings:
Inspectors found that while there were appeared to be appropriate levels of staff on the day of inspection to meet residents' needs and the layout of the premises, there was no assessment of the needs of residents completed to determine if the number were appropriate. Staffing levels and skill mix need to be reviewed in light of the findings in outcome 14.

Inspectors reviewed four staff files and found that written references were in place, however, they did not fully contain all of 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. They did not include a vetting disclosure for two staff, inspectors were informed that vetting would be applied for these staff. Inspectors also noted that while employment histories were on file, there were gaps in employment histories which had not been explored.

There were appropriate staff supervision arrangements in place. Inspectors read the individual performance reviews of staff and they appeared comprehensive. The person in charge had completed training in this area. Additional support and supervision was provided to staff as required.

Over all education and training provided to staff to enable them to provide care in accordance with evidenced based practice required improvement. Inspectors found that not all staff had received manual handling training, government guidance for the protection and welfare of children and fire safety training. Staff had not received training

on the Regulations and National Standards, medication management and epilepsy management See Outcome 11. A training plan for 2014 was shown to inspectors and this included autism and mental health issues.

Inspectors found that residents' privacy and dignity was respected by staff. Staff interacted with residents in a courteous manner and addressing them by their preferred names. Inspectors observed good interactions between staff and residents who chatted with each other in a comfortable way.

Inspectors noted that a volunteer was in the process of being vetted but the roles and responsibilities were not clearly defined.

Staff explained that while residents attended training sessions in the other communities on issues such as relationships, there was no follow through to the staff caring for the residents. Therefore should issues arise they may not be dealt with by the staff.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate
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Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	ORG-0011520
Date of Inspection:	25 March 2014
Date of response:	23 April 2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The assessments were not fully inclusive of resident's specific social, emotional, participation needs, preferences and preferred routines.

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

Please state the actions you have taken or are planning to take:
● HSE has been contacted requesting a psychological assessment for two of our residents as a matter of urgency.
● A multidisciplinary needs assessment tool will be in use following training of staff

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

during May ’14 and will be incorporated into training of staff re writing of personal plans and completion of personal plan reviews by Mid June.
● Mainstream service and external professional expertise will be consulted and invited to contribute to the assessment process as appropriate.
● Appropriate risk assessments will be undertaken as part of the planning process.
● Resident’s personal outcome goals will be incorporated in to their personal plans which will enable effectiveness of plans to be measured.
● A review of the arrangements in respect to access to living space will be conducted in consultation with the residents – completion date; Mid May.

Proposed Timescale: 15/06/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The personal plan did not fully reflect the assessed needs of residents.

Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
A new assessment of need tool is being rolled out in the service during May.

● The roles and responsibilities of all staff are presently being reviewed, with job descriptions and responsibility profiles being confirmed which will clarify roles in the assessment and personal planning process.
●
Each personal plan is reviewed yearly on the individuals birthday, and three monthly thereafter.
A key worker has been appointed to each individual since the 07/05/14, they will be involved in assisting the person to complete the form and to achieve their goals. They will assist in incorporating risk assessment mitigation into the planning process. A goals achievement form has now been attached to each personal plan, one sheet for each goal, this is then supported and monitored by the SCW.
The personal plan is presented to the individual at least two weeks prior to the review date so as they can read and fill it in, this includes the individual’s assessment of whether goals were achieved, barriers to achievement and what new goals should be set.
The plan is reviewed with the Social Care Worker (SCW), Co-Worker/Staff, multi disciplinary team members and the individual, the person invites the people they feel relevant, (usually family members, advocate, friends).
We have also attached a care assessment and care plan to the personal plan which will include personal safety.
In addition to the individual and Social Care Worker signing off the Personal Plan/Review, it is also signed off by the Person in Charge.
A social worker post has been advertised and will assist the centre with needs assessment and risk management.

Proposed Timescale: 30/06/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was a lack of a robust system to assess the effectiveness of residents personal plans.

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

Please state the actions you have taken or are planning to take:
The assessment of need will inform the subsequent review of all residents personal plans which will be undertaken and completed by 15/06/14.

● Scheduled quarterly reviews of personal plans will be undertaken. Where there has been a substantive change in personal circumstances or via the annual review process a comprehensive need assessment will be conducted and an updated/new personal plan will be completed.

● A personalised whole life/quality of life core dimension approach is adopted in the consideration of resident's goals which includes:
Independence; e.g. personal safety.
Social inclusion; e.g. accommodation, work, learning, leisure.
Physical well being; e.g. personal hygiene, diet, health.
Emotional well being; e.g. mental health, friendships, dignity.
Goals are resident led and support is put in place to support achievement of goals.

● The personal plan including resident's goals is now incorporated into the day to day support work with residents through a more inclusive practice of sharing plans and goals with all relevant support staff and co-workers.

● The review of resident's personal outcomes in personal plans will enable effectiveness of support and plans to be measured at an individual level. Personal plans will in the review process, if required, be amended to enable better achievement of goals.

● A national audit tool will be used to assess consistency and standards of all personal plans in the Community against set criteria. This will in turn inform best practice. To be conducted 13/06/14.

Proposed Timescale: 15/06/2014

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:
The risk management policy did not include the identification and assessment of risks throughout the designated centre.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
• The Person-in-Charge and all staff are receiving practice and training support around risk management from an experienced person in charge from another community and the independent Health and Safety Consultant of Camphill Communities of Ireland.
• The risk management policy framework is being reviewed to ensure there is a site specific risk management policy and procedure in place; it will include centre specific risks such as risks associated with fire safety and emergency planning and risks related to the living and working environment. It will also include personal risks such as self harming and aggression.
• A review of risks associated with independent living will reviewed as part of the personal plan review programme and will include the local incorporation of the absent without leave policy into local practice. In respect of independent living the Centre will focus on risk enablement to ensure the desired outcome of residents to optimise their independence is met.
• The designated centre's risk register is being updated and include opportunity for learning and review.

Proposed Timescale: 31/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems for the identification, assessment, management, recording and investigation of risk required improvement.

Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
A more robust system is being put in place to record and review incidents and adverse events, to identify potential risks to individuals and risk escalation, and to identify and record learning, in line with the recommendation of the report of the investigation into incidents of suspected abuse.

The risk management policy is being updated to include localised and specific risks including self harm, aggression and violence, absent without leave. Individual safety plan and/or positive behaviour support plans for residents are incorporated into the personal plans for each individual as required.

Learning from accident and incidents is reviewed by the Person in Charge and discussed at the staff management meetings. Incorporation of learning into practice will form part of the standard process of such meetings and placing of any associated risk on the Risk Register. All accidents and incidents are reported to the Person in Charge and Provider prior to reporting as required to HIQA. Learning from incident and accidents are shared with peers from other communities as a standard agenda item through the monthly Collaborative Learning Group and a learning log is in place. This can be then be brought into the National Risk Register as required. Reporting also takes place to the Council on a monthly basis.

• Discussion has taken place with residents and families around risk taking including agreement on improved sharing information and monitoring arrangements when a person leaves the Centre thus reducing the risk of absence without leave. There has been an agreed strengthening of protocol for managing absence. Where required, individual safety plans are being incorporated in personal plans.

• All staff/co-workers are receiving practice and training support around risk management from an experienced person in charge from another community and the independent Health and Safety Consultant of Camphill Communities of Ireland.

• The designated centre's risk register is being updated and include opportunity for learning and review.

• The Centre’s Emergency Plan is being updated to include alternative accommodation arrangements.

• A review of the records from fire drills will be undertaken to identify and incorporate learning outcome improvements that require to be addressed.

• All fire safety equipment has been serviced and records are available to demonstrate they are in place.

Proposed Timescale: 31/05/2014

Theme: Effective Services

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

The system for responding to emergencies required improvement.

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:

A system is being put in place for reviewing incidents, and for identifying risk escalation and learning, and for recording same.

The Emergency Plan of the designated centre is being updated to include site specific hazard, and individual evacuation plans.

Proposed Timescale: 09/05/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire training had not been provided to all staff and fire training only included the use of fire extinguishers.

Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
Fire training for all staff and residents by a highly qualified trainer was completed on the 02/05/14.

A chartered fire and safety engineer report has been received; proposals for implementation of recommendations are being drawn up and a qualified person has been sourced to implement recommendations.
A risk assessment of emergency lighting and adequate control measures has been reviewed with the Health and Safety Consultant of Camphill Communities of Ireland.

While awaiting implementation of the full recommendations on emergency lighting, the recommendation of the H&S Consultant re interim actions have been implemented and the following steps have been taken:
Plug in night lights have been installed on the landings and hall ways of all the houses.
Hi vis strips on the steps to show the way with exit signs on the walls are being installed.
All Service Records of equipment have been obtained and are on file.

Proposed Timescale: 31/07/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures in place to protect residents in the designated centre were not robust.

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:
• All staff and co-workers will receive further training in Adult Protection scheduled for 10/04/14 and this will ensure all staff and co-workers have achieved the national CCoI minimum standards in safeguarding. Two members of staff will undertake MAPA training on 12/04/2014. Fire Safety training is scheduled for 02/05/2014. PiC is currently undertaking management training. Further training for key staff is being put in place.

● The report recommendations from the Adult Protection Investigation will be implemented by 18/04/2014.

● A review of safeguarding measures which are in place for all residents has been facilitated by the person in charge from Camphill Grangebeg. Immediate action has been taken to update the risk assessments and the challenging behaviour support plans for two residents. Ongoing reviews are in place for all other residents. Lessons learned from the review exercise are ensuring that expertise and best practice will be shared across the team particularly in the area of risk assessment and risk enablement.

● A risk assessment for children who were residing in the community was completed. There are currently no children residing in the community. There is a visitor's policy in place.

● Staff supervision arrangements have been reviewed and updated. The PiC will receive increased supervision from the Provider as well as practice support from a PiC colleague.

● There has been a review of the complaints/safeguarding management arrangements. A full time Children First trained staff member has been appointed as the designated officer and the Person in Charge has overall lead responsibility. All staff have been informed of the arrangements.

● Protection and dignity of residents will continue to be a standing agenda item at all house and care group meetings.

Proposed Timescale: 02/05/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that incidents of suspected abuse were appropriately investigated and managed in line with the centre's policy and the legislation.

Action Required:
Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:
The immediate safety of the resident was addressed. The family were advised of the matter.

A screening report concerning two incidences of suspected abuse has been compiled and referred to the National Case Management Team.

Notification of the events has been sent to HIQA.

An investigation has been carried out. The investigation report and findings were received 04/04/2014

The recommendations of the investigation report are being actioned and will be implemented by 18/04/2014

The co-worker involved in the alleged abuse is no longer resident in the community and is not involved in duties with any of the residents or day attendants.

Proposed Timescale: 18/04/2014

Outcome 09: Notification of Incidents

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The Authority had not been notified of any allegation, suspected or confirmed abuse of any resident.

Action Required:
Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

Please state the actions you have taken or are planning to take:
The Authority had been notified of the two cases referenced.

• The Authority has received the Investigation and Findings Report into these two instances.

Proposed Timescale: 04/04/2014

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medication management required improvement as outlined in Outcome 12.

Action Required:
Under Regulation 29 (4) (a) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.

Please state the actions you have taken or are planning to take:
• The medication management administration records have been strengthened including improvement in signage. Photographic identification is in place for all residents.
• All staff involved in medication management received training in policy and procedure in respect of the safe administration of medication – 24/04/14.
• A further session is scheduled for completion by 31/05/14 and includes epilepsy training delivered by qualified lecturer/medical professional.
• A follow up unannounced audit of medication management will take place during May 2014 by an external qualified pharmacist on behalf of Camphill Communities of Ireland.
• Following consultation with the GP of residents who are self administrating their medication, staff and residents are clear about responsibilities. The practice of self administering medications for residents has been reviewed to ensure compliance with policy.
• Risk assessment of resident's with special medical condition such as epilepsy will be undertaken and plans to guide care will be put in place.
• Further training of staff in medication management will be ongoing.

Proposed Timescale: 31/05/2014

Outcome 14: Governance and Management

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge of the centre was not sufficiently knowledgeable of her statutory responsibilities and there were a number of non compliances in the responsibilities of the person in charge.

The person in charge did not engage in the governance of the centre on a consistent basis.

Action Required:
Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the

qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

Please state the actions you have taken or are planning to take:
• The Person-in-Charge is full time employed in Centre and is responsible for the day to day operations of the Centre. The person in charge holds weekly staff meetings with all staff to discuss any issues that arise. She line manages all staff and co-workers who work directly to her. The Person in Charge also attends weekly meetings with residents. The Person in Charge is responsible for directly reporting on business of the Centre to the Local Committee and Provider and via monthly reports to the Council of Camphill Communities of Ireland.
• A schedule of work priorities and targets has been put in place based primarily on the HIQA Action Plan.
• Person-in-Charge is receiving monthly minuted supervision with the Provider's nominee over the next three months after which there will be a quarterly appraisal. Ongoing supervision will subsequently take place on at least six weekly intervals.
• The Person in Charge is receiving comprehensive training and support to strengthen her experience, knowledge and skills. This includes:
• Ongoing practise support from nominated person in charge from another community.
• Person-in-Charge is receiving peer mentoring support of her role with colleague from another designated centre
• Person in Charge is completing a self learning evidence workbook on the Fit Person Entry requirements. The first section covered legislation and regulations. Further sections will include staffing, governance and management. The evidence workbook is being peer reviewed. The Person in Charge will undertake an external Fit Person interview to confirm knowledge and understanding of responsibilities by end of July 2014.
• Person in Charge attending training on Regulations and National Standards on the 23/05/14.
• Person-in-Charge will continue with group supervision and training for PICs of Camphill Communities of Ireland.
• Person-in-Charge is presently in undertaking an Open Training College Certificate in Applied Management HETAC level 6 to achieve a certified management qualification.
• Person-in-Charge has undertaken recent training in:
• Safeguarding training received 10/04/14 with follow up Children First trained proposed prior to end of July.
• Sexuality, decision making capacity and current legislation ; M.Sc Seminar TCD 25/04/2014

Proposed Timescale: 31/07/2014

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 clearly defined and the lines of authority and accountability, roles and responsibilities for all areas of the service were not clearly defined.

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:
● Roles and responsibilities of staff have been clarified with job descriptions and responsibility profiles, which have been distributed in writing and signed off by staff/co-workers.
● The personal plans of residents have been made available to staff providing care as appropriate, and the dissemination of relevant information has been made available as appropriate.
● A key worker has been appointed to each individual since the 07/05/14, the key worker will work directly with a resident in providing information, developing and inputting to the individual's personal plan
The plan is reviewed with the Social Care Worker (SCW), Co-Worker/Staff, multi disciplinary team members and the individual, the person invites the people they feel relevant, (usually family members, advocate, and friends).
All Personal Plans/Reviews are also signed off by the Person in Charge.
● Once the assessments of needs of residents have been completed the key support workers will be tasked to ensure these are fully met. They will be assisted in this by the social care worker, and the social worker that will be appointed by mid June.
● Timetabled professional and developmental supervision is in place for all staff.
● Structured and timetabled line management supervision/support has been put in place for all staff and co-workers and annual appraisal reviews for all are in place.
● Governance chart in place that clearly identifies lines of authority and accountability.

Proposed Timescale: 15/06/2014

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The information and documents as specified in Schedule 2 were not obtained for all staff.

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 Garda Vetting Unit has advised the National Governance Co-ordinator of the CCOI that the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 has not come into effect as yet. The Vetting Unit had directed CCOI to continue with our current procedures until the 2012 Act has been implemented. Naturally we will fully comply with the new system in respect of the 2012 Act once it has been implemented.

We will continue to seek vetting from the individual's home country as an additional precaution as the Garda Vetting Unit has clearly indicated that they will not be vetting them in their home country.

Application has been made to the Garda Vetting Unit in respect of the two foreign nationals. We are currently awaiting a response from Unit. All other staff has Garda clearance.

The Person in Charge requires records to demonstrate compliance with Schedule 2 of Regulations for all new staff/volunteers to be submitted to her for sign off prior to commencement of employment.

Proposed Timescale: 15/06/2014

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no assessment of the needs of residents completed to determine if the number and skill mix of staff were appropriate.

Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
The roles and responsibilities of present staff have been clarified and confirmed, with job descriptions and responsibility profiles being put in place.

A social worker post has been advertised who will assist the centre with needs assessments, risk management and provide guidance and support in Adult Protection and Complaints.

Following the completion of the needs assessment and review of personal plans for residents, there will be a review of staffing levels, skills and qualifications to ensure that any gaps are identified and resourced in order to provide excellent and timely quality support.

Proposed Timescale: 25/06/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Education and training was not provided to staff to enable them to provide care in accordance with evidence-based practice.

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:
● All staff have received updated safeguarding training from the PIC of another community, and the designated Safeguarding Officer (10/04/2014). The Safeguarding Audit tool will affirm that staff understand the policy and procedure and are now clear about how they should respond to allegations of abuse. The tool will also identify further training needs that will be undertaken over the next four weeks.
● Management of Actual or Potential Aggression (MAPA) training for all staff completed 25/04/2014.
● Manual Handling training for all staff scheduled completed 22/04/2014.
● Fire Training scheduled for May, 2nd 2014 for all staff.
● Epilepsy management training for all relevant staff to be completed by 31/05/14
● Training on the Regulations and National Standards will be held on the 23/05/14
● Person in charge and other relevant staff to receive Children First Training
● Person in charge and Social Care Worker attended training around sexuality and decision making capacity in TCD on 25/04/2014
● The Induction Programme for all junior support workers and new staff is being reviewed to ensure that relevant training is provided to enable staff to provide adequate care and ensure best practice

Proposed Timescale: 30/06/2014