Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Camphill Community Callan
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	08 January 2019
Centre ID:	OSV-0003607
Fieldwork ID:	MON-0025761

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

The providers statement of purpose describes the service as providing long-term residential services for 12 adult residents. Both male and female adults with an intellectual and/or physical disability, autism, and challenging behaviours could be provided services in this centre. The centre is located in a rural village and comprises of two residential units and five individual units for single residents supported as required by staff in close proximity to each other.

The following information outlines some additional data on this centre.

Current registration end date:	24/10/2019
Number of residents on the date of inspection:	12

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
08 January 2019	09:30hrs to 19:00hrs	Noelene Dowling	Lead
08 January 2019	09:30hrs to 19:00hrs	Conor Dennehy	Support

Views of people who use the service

Inspectors met and spoke with five residents over the course of this inspection. The residents informed inspectors that they were very satisfied with their lives in the centre. Residents continued to do all of their favourite activities and informed inspectors that they had many plans for the New Year. Residents could discuss concerns with the staff and the managers and stated that they were listened and responded to.

Residents informed inspectors that they felt safe living in the centre. Some did say that they would welcome an increase in their funding for the service as they would have more freedom to make decisions regarding their activities and choices. They understood that this was not something HIQA had any influence over. Residents confirmed that staff supported them with managing their money and saving for their special occasions such as holidays or trips away with their various groups.

Capacity and capability

This was the fifth inspection of this centre which last inspected in August 2017. The purpose of this inspection was to monitor ongoing compliance with the regulations and standards. This inspection was also informed by information notified to HIQA.

HIQA acknowledges that the findings in relation to the governance and oversight in this report are significantly influenced by a number of factors. Namely, that the person in charge was also supporting another of the providers centre's for a significant period in 2018 resulting in insufficient oversight by senior management.

The findings in the report detailed in the quality and safety section of this report on care planning and reviews, risk management, unsafe admissions and safeguarding decisions demonstrated a lack of capacity to provide a safe and effective service.

The actions from the previous inspection in 2017 in relation to essential elements of oversight by the provider to ensure the service was safe, including the supervision of the person in charge, undertaking of internal unannounced inspections and a annual review of the quality and safety of care had not been implemented. However, since December 2018, following intervention by HIQA, the provider had implemented robust changes to the national and local governance arrangements.

To this end, there was evidence of planned changes to the systems for monitoring

of practices and response to incidents which was demonstrating more robust and effective support. On the day of the inspection the regional manger was undertaking a review of the service.

There was evidence of auditing of accidents and incidents, medicine errors and incidents of challenging behaviours .These demonstrated appropriate responses and monitoring. For example, changes to medicines management practices had resulted in errors significantly reducing.

Staffing levels and skill mix had improved. There was evidence of a significant staff shortage in the summer months and a lack of oversight in one unit particularly. However, this had stabilised and inspectors were satisfied that the numbers and skill mix of staff was suitable for the residents. A number of residents had one to one staffing and stable staff which offered security and consistency to them. Inspectors observed that the residents and staff were communicating and interacting in a relaxed and respectful manner.

In line with the providers ongoing and agreed changes, the staffing model was in the process of change with the reliance on long term co-workers (volunteers) being reduced. This and the role of the short-term volunteers was being reviewed but had not yet been fully implemented in this centre. The volunteers did however, have specific hours of work and appropriate time off which was an improvement.

Inspectors were advised that long-term co-workers who remained as volunteers would have very specific and monitored functions for limited roles.

Recruitment procedures were reviewed and the inspector found good procedures overall. However, inspectors saw that information procured for persons who undertake significant individual work with residents such as counselling was not satisfactory. Staff supervision and mandatory training was found to be in place.

From a review of the complaints records inspectors found that the residents concerns were listened to and addressed and they confirmed this to the inspector

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced and at the time of the inspection was engaged full time in the post.

Judgment: Compliant

Regulation 15: Staffing

The staffing level and skill mix was suitable to meet the residents assessed needs.

Procedures for recruitment were satisfactory for direct employees. However improvement was required to ensure therapeutic interventions were provided by appropriate professionally trained practitioners in accordance with clear organisational policy.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had the required training and supervision to enable them to support the residents.

Judgment: Compliant

Regulation 23: Governance and management

While there was evidence that systems for improved structures were being implemented, the findings in safeguarding, risk management and personal planning do not demonstrate sufficient managerial oversight in the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Admission procedures were not satisfactory or implemented in a manner so as to ensure that residents could be protected from abuse and that arrangements for them were satisfactory.

Judgment: Not compliant

Regulation 3: Statement of purpose

The care delivered was seen to be congruent with the statement of purpose.

Judgment: Compliant

Regulation 30: Volunteers

Formal procedures for persons acting or wishing to take up roles of volunteers are required to ensure their roles and responsibilities are set out in writing.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From a review of the accident and incident records the person in charge was notifying the chief inspector of all maters required.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were being managed transparently and resolved in a timely manner.

Judgment: Compliant

Quality and safety

Inspectors found that residents had a good quality of life in the centre with very good access to social and recreational and meaningful activities of their own choosing. Residents were seen to be fully consulted in regard to their own care needs and actively involved them in all decisions. Residents told inspectors that they attended art works shops, participated in drama groups, were supported to have their own hobbies' such as music and had good access to their community, and holidays and trips of their own choice. Residents did work experience which they said they enjoyed and which gave them additional funds.

Residents had information about various referendums, voting in elections and were familiar with support groups for vulnerable persons. A number managed their own monies and medicines with staff support.

The adequacy of risk assessment and management in relation to safeguarding and

health and safety required review.

Inspectors found that risks were not evaluated in a consistent and considered manner. Overall there was good attention to residents safety and emergency plans were in place. However, there had been no risk assessment or revised risk management plan implemented following a serious incident with a resident.

Evacuation procedures also required review. In one unit fire drills were held at the same time and were seen to take between four and six minutes to evacuate the building. This did involve the use of an evacuation chair and a number of stairways for one very dependant resident. The time line involved had not been reviewed to ensure it was safe or if there was a more effective alternative. There was evidence of timely servicing and monitoring of the fire safety management systems. Exits were protected which negated the risk somewhat.

However, inspectors were concerned with a number of actions and decisions taken by the provider which effectively resulted in both risk and direct harm to residents. This included failure to adequately assess and obtain the pertinent information for an admission to an independent unit supported by the providers staff. Persons living in this unit had full access to the designated centre which was not found to be appropriate.

From a review of the records in relation to this admission it is apparent that the discharging centred failed to provide adequate information on the specific risks and needs of the new person. However, it was also found that despite evident concerns as to risk and suitability of placement, the provider proceeded with the arrangement. No specific training was given to the support staff and no adequate risk assessment or management plans were implemented. This ultimately led to the abuse of two residents and effectively negated the duty of care to the person admitted who was also a vulnerable adult. Inspectors saw that once the abuse was disclosed the correct safeguarding procedures were implemented.

Inspectors found that there was a commitment to supporting residents to develop the skills and confidence to protect themselves and in the above instance they were able to promptly disclose the incidents. The staff supported them with training in managing situations in the community and ensuring that they had quick access to staff and mobile phones. This was seen to have been of benefit to residents. Peer to peer incidents were managed well and resolved reasonably.

Residents had very good access to health care pertinent to their assessed needs and allied services including physiotherapy, occupational therapy or dieticians. However, there were some inconsistencies found in residents personal plans and reviews of their care needs. A number of plans reviewed were very comprehensive, person-centred and showed evidence of review. It was apparent that any goals identified were being achieved with the residents.

This was not consistent and in one instance no personal plan or assessments had been undertaken or implemented since the residents admission in early 2017 and another resident had no review undertaken. This resulted in a lack of clarity for staff

as to how best to monitor and support the residents.

Training in a revised model of supporting residents with behaviours that challenged was ongoing for staff.

Inspectors found that medicines management systems were good and medicines were reviewed. However, intimate care plans for the use of topical homeopathic remedies were not in place to ensure residents bodily integrity was respected in the administration of these medicines.

Regulation 13: General welfare and development

Residents were supported and encouraged to participate in a range of activities and training according to the need and preferences.

Judgment: Compliant

Regulation 26: Risk management procedures

Systems for the adequate evaluation and management of known risks were not consistently implemented.

Judgment: Not compliant

Regulation 28: Fire precautions

While fire safety prevention and management systems were in place the procedure for the safe evacuation of residents required to be reviewed for effectiveness.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Systems for the management of medicines were satisfactory and medicines were reviewed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans based on up-to-date assessment of needs were not consistently implemented or reviewed in a timely manner to ensure the care delivered was suitable for the residents.

Judgment: Not compliant

Regulation 6: Health care

Residents health care was monitored and responded to promptly in a a manner pertinent to the residents needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff had revised training in supporting residents with their behaviours and additional assessment and clinical guidance was being provided.

Judgment: Compliant

Regulation 8: Protection

Systems to ensure that residents were protected from potential or actual abuse were not sufficiently implemented. Intimate care plans gave no guidance to staff as to the safe and dignified administration of alternative topical medicines.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents rights were promoted and supported by staff who actively advocated on their behalf.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community Callan OSV-0003607

Inspection ID: MON-0025761

Date of inspection: 08/01/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing levels have increased since summer 2018 in one unit, with two deputy House coordinators in place since December 2018 and one care assistant since February 2019. Further review of staffing levels is ongoing and levels are monitored on an ongoing basis. LTCW transition to employment or local volunteer positions is in process, all have employee contracts or local volunteer agreements and job description/ responsibility agreements in place. STCW review report and recommendations will be implemented once finalised, report submitted to board of directors and actions approved. For all therapists/ counsellors/ life coachers working with residents will have sufficient experience and proof of professional qualification for their respected work in their HR files and registration with professional body and garda vetting, in accordance with organisational policy. This policy will be reviewed by the HR officer and the national management group by before the 3rd quarter of the year.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Supervision schedule for PiC is in place on a six weekly rotation. Regional manager will be present in the Service every two week for one day to attend management or welfare meeting and liaise with PIC on current matters. RM reviews all incidents reports weekly and a receives a weekly report on resident wellbeing, H&S, HR and current matters.	

House coordinators send weekly report to PIC or deputy PIC to supply information for weekly report to RM. Annual review has taken place on the 8th of January and the compliance plan will be finalized. Internal unannounced inspection by RM will take place by May 2019 and second one is scheduled for 3rd quarter in 2019. Lean project is being rolled out, national Safeguarding officer has overview of all incidents, national flow chart of dealing and notifying with safeguarding concerns is in use, quarterly national meeting all DO' to ensure organizational learning and oversight. Internal audit schedule of residents plans is in place. PIC part of national Quality and safety working group, meeting monthly.
KPI reports are send to national management team on a monthly basis, covering staffing numbers and changes, incidents and accidents, safeguarding, Trust in Care and residents admissions and discharges.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Admission policy procedure is reviewed locally.
Any new admission will be in line with the policy and by authorization of RM and national management team and safeguarding concerns are reviewed and risk assessed.

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
LTCW transition to employment or local volunteer positions is in process, all have employee contracts or local volunteer agreements and role agreements in place.
STCW review report and recommendations will be put in place.
All stcw will have responsibility profile.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk

management procedures:
RM reviews all incidents reports weekly and a receives a weekly report on resident wellbeing, H&S, HR and current matters. House coordinators send weekly report to PIC or deputy PIC to supply information for weekly report to RM.
All incidents will be risk assessed and written risk assessment will be in place.
New H&S officer to start with remit for H&S, fire safety and social care risk management.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drills will happen quarterly and at different times over a 24 hour period. Fire drill records will identify all relevant details of each drill and reviewed by H&S officer.
Individual evacuation plan will be reviewed.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All personal plans will be up to date in accordance with organisational policy and reviewed by PIC/Dep PIC on a quarterly basis. Weekly report from house coordinator to PIC will inform if plans are in date and what actions are needed for the week following.
Report writing, positive behavior support, health assessment, autism awareness and circles of support training for staff will take place to enhance skill and knowledge.
Conduct audits of date using HIQA tools.
Part of weekly report to RM ensures spot checks on residents PCP.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Intimate care plans will outline the use of topical homeopathic remedies to ensure bodily integrity is respected. Clear guidelines for staff will be in place, signed off by GP.
Qualified nurse will commence supporting service for 2 hours weekly.
Admission policy procedure is reviewed and updated.

Any new admission will be in line with the policy and by authorization of RM and national management.
Camphill has recently completed a LEAN Safeguarding Process project which was completed on 29th January 2019. This process and flowchart is currently being reviewed by ACRUX as part of our Safeguarding Performance Improvement Plan.
This will then be introduced and implemented throughout Camphill Communities of Ireland

Lean project recommendations are being implemented.
Training sessions on advocacy, safeguarding in relation to social media, relationship and sexuality are taking place with residents.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall 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.	Substantially Compliant	Yellow	01/04/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	15/02/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Not Compliant	Orange	28/02/2019

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	28/02/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/05/2019
Regulation 24(1)(b)	The registered provider shall ensure that admission policies	Not Compliant	Orange	15/02/2019

	and practices take account of the need to protect residents from abuse by their peers.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	15/03/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	31/01/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/01/2019
Regulation 30(a)	The person in charge shall	Substantially Compliant	Yellow	01/04/2019

	ensure that volunteers with the designated centre have their roles and responsibilities set out in writing.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/02/2019
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Yellow	31/01/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/02/2019