Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Camphill Community Dunshane
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	18 December 2018
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0025737

About the designated centre

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

Dunshane Camphill Community is a registered designated centre that according to its statement of purpose and function provides 24-hour, seven day residential services on a 52 week cycle each year for 26 residents. The centre also provides day activation services from 9am to 5pm Monday to Friday, onsite. Some residents also participate in day activities, such as baking, cooking, pottery, farming, etc., in other Camphill Communities or with other organisations. The centre aims to provide a safe residential community setting where residents are cared for, supported and valued, within a care environment that promotes the health and well-being of each resident. The service aims to provide a person centred approach to service provision. This was the sixth inspection of this designated centre by HIQA since commencement of regulation in 2013. This inspection focused on the area of risk and safeguarding following receipt of solicited and unsolicited information by HIQA.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

How we inspect

To prepare for this inspection the inspector or 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
18 December 2018	11:00hrs to 16:30hrs	Conor Brady	Lead

Views of people who use the service

There were 24 residents on the date of inspection with two vacancies. Inspectors met with 20 residents over the course of this unannounced inspection. Each resident communicated with inspectors on their own terms and in line with their own communication preferences. The majority of residents were found to be appropriately supported over the duration of inspection and were observed coming and going to various social and vocational programmes on and off site.

Overall feedback from residents was very positive on this inspection. Residents spoken with stated that they liked living in the centre and felt happy and safe in Dunshane. The inspectors found some residents who had transitioned into the centre were doing very well in Dunshane. Inspectors were also informed that other residents who had transitioned into the centre were moving to other services as they did not find the service was suited to their own individual needs and was too rural. The provider was supporting these residents to transition to other more appropriate service providers in line with the residents' preferences.

Inspectors observed knowledgeable staff who residents presented as very well supported and comfortable with. Residents spoken with told the inspectors that they were well cared for and supported by the staff in this centre.

Capacity and capability

Overall the capacity and capability of this service was found to be operated to a reasonably good standard in terms of local governance and management. The standard of management and monitoring of care and support in the centre had substantially improved across a number of areas. However some further improvements were required in terms of staffing provision and full and comprehensive governance oversight over some key areas.

The registered provider had made a number of changes at board, executive and senior management level since the last inspection. The providers head office was based at Dunshane and the Chief Operating Officer was met as part of this inspection and attended inspection feedback.

The person in charge (who was a qualified social care professional) was on leave on the day of this inspection. However, the inspectors observed that there were adequate arrangements in place for the operational management of the centre in her absence.

There were two skilled, experienced and qualified persons participating in management overseeing the day-to-day operations of the centre and the inspectors met and spoke with both of them over the course of the inspection. They were found to be aware of their remit to S.I. No. 367/2013 - Health Act 2007 (Care and

Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations), responsive to the inspection process and knew the needs of the residents very well.

The person in charge along with the management team ensured staff were appropriately qualified, trained, supervised and supported so as they had the required skills to provide a responsive and effective service to the residents. The inspectors spoke with ten staff members over the course of this inspection and were assured that they knew the needs of the residents very well and had the skills, experience and knowledge to support residents in a safe and effective manner.

From a sample of staff files and records reviewed, inspectors also observed that safe and effective staff recruitment practices were in place. Additionally, many staff held relevant third level qualifications and had undertaken a suite of in-service training to include Safeguarding of Vulnerable Adults, Children's First, Fire Safety, Patient/Manual Handling and Safe Administration of medication. Where required, staff also had specialised training so as to meet the assessed needs of the residents. This meant they had the knowledge and skills necessary to respond to the needs of the residents in a consistent, capable and safe way.

However, the staffing arrangements required review as at times, there was inadequate staffing cover to provide for some of the assessed needs of some residents. For example, due to the current staffing arrangements in place it was not always possible to provide 1:1 staff support to a resident (as required by their risk assessment) and some social care activities were being postponed or rescheduled due to inadequate staff cover in one part of this designated centre. In reviewing rosters, discussing this with staff, management and residents it was determined there was not sufficient staffing cover in this part of the centre which required review.

Regulation 15: Staffing

On completion of this inspection, the inspectors were satisfied that staff had the knowledge and skills required to support the residents in in a caring and person centred manner. There were systems in place so as to ensure staff were supported and supervised on a regular basis. However, the staffing arrangements required review as at times, there was inadequate staffing cover to meet some of the assessed needs of some residents

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were provided with all the required training so as to provide a safe and effective service. From a sample of files viewed the inspectors saw that staff had

training in Safeguarding of Vulnerable Adults, Safe Administration of Medication, Positive Behavioural Support, Fire Safety and Manual Handling. There were also systems in place to ensure that refresher training was provided to staff as required. Where required, staff also had specialised training to support residents with health related conditions such as diabetes.

Judgment: Compliant

Regulation 23: Governance and management

Overall governance and management had improved in this centre. However the inspectors found some of the oversight and monitoring changes planned to come into effect in January 2019 should have been implemented following the previous HIQA inspection in February 2018.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspectors were satisfied that the statement of purpose met the requirements of the Regulations.

The statement of purpose consisted of a statement of aims and objectives of the centre and a statement as to the facilities and services which were to be provided to residents.

It accurately described the service that will be provided in the centre and the person participating in management informed the inspectors that it would be kept under regular review

A minor issue was identified with regard to the organisational structure of the centre recorded on the statement of purpose however, once brought to the attention of management they assured the inspectors that this would be addressed as a priority.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications were received by HIQA where required and were reviewed on inspection. A large number of safeguarding notifications were reviewed and found to

have been followed up by the provider.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

While not required to be notified in this instance. The managerial arrangements in the absence of the person in charge were inspected on this inspection and found to be professionally appropriate.

Judgment: Compliant

Quality and safety

The quality of care and safety of residents was reviewed in detail as part of this inspection. Residents were found to be well supported and cared for in a number of ways by the registered provider. Many residents were found to enjoy a good quality of life in most instances and informed inspectors they felt safe and very happy in their service. However further improvements were required in the areas of risk management, behavioural support and safeguarding as evidenced on this inspection.

Most residents in the centre were found to be well supported and presented as very content and happy over the course of inspection. There were good activation levels for many residents and multiple activities available in the centre. Inspectors spoke with many residents and some reviewed their personal plans with inspectors citing that they loved their home and were happy with the staff who supported them. Residents participated in baking, weaving, farming, cooking and various rural work around the community. Some residents with an interest in fitness went to the gym and one recently purchased a treadmill and others were observed preparing for the Christmas festivities and Christmas show.

Residents had clear and comprehensive personal plans in place that outlined their needs, wishes and preferences. Social goals were set in consultation with residents. Health care needs were supported through links with community allied health professionals such as G.P. psychiatry, psychology and dentist. Some residents were on waiting lists awaiting appointments following referral by the provider.

In terms of risk management the inspectors found that there were systems in place regarding the review and monitoring of risks. Managers and staff reviewed risks, logged incidents and accidents and had a risk register in place. External health and safety, road safety authority (provider vehicles) and fire services audits were evident. Welfare meetings occurred on a weekly basis where various risks were

discussed. However there was a notable disconnect between the centres risk register and the system in place for accidents and incidents oversight and analysis. For example, there was not a direct correlation between the assessment of risk in the risk register and the prevalence of risk that was actually occurring in the centre. This resulted in a primarily reactive approach to risk management in the centre.

From a safeguarding perspective the high number of safeguarding notifications was reviewed and a number of safeguarding incidents, plans and issues were examined with the safeguarding officer on inspection. There were systems in place whereby safeguarding was identified, reported and managed appropriately by the provider. Staff were appropriately trained and the safeguarding matters identified on the previous inspection had been addressed by the provider. Residents informed the inspector that they felt safe and well supported. Financial safeguards required improvement to ensure the appropriate review and safeguarding of residents finances. In addition, some residents who required increased therapeutic supports in terms of complex behavioural support needs required more support to ensure appropriate assessment led guidance was in place for staff supporting these residents.

Regulation 26: Risk management procedures

Inspectors found that while there was good understanding and staff knowledge of risks across the centre, there was a disconnect between the centres risk register, accidents and incidents oversight and analysis, the role/remit of the risk, health and safety manager and other managers in the centre. In addition, the risk assessments and control measures in some parts of the centre were not found to be implemented appropriately.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Individual assessments and personal plans were found to be comprehensive, clear and accessible to residents. Residents were well consulted in their personal planning and plans were devised in line with residents needs, wishes and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to access appropriate allied health care professionals and pursue best possible health. There was not provider multi-disciplinary input and

therefore residents utilised HSE/community care services and were therefore subject to waiting lists in some cases reviewed. However appropriate referrals were being made where required by the service provider.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was not an appropriate and comprehensive positive behavioural support plan in place for all residents assessed as requiring same.

Judgment: Not compliant

Regulation 8: Protection

There was a high number of safeguarding referrals to HIQA from this centre and these were reviewed as part of this inspection. A provider assurance report was requested by HIQA in the month prior to this inspection and some of the corrective actions and steps associated with this were found to be in process. Inspectors found that residents were being appropriately safeguarded in the centre with incidents followed up appropriately and referred to HSE/An Garda Siochana where required. Further oversight was required regarding the monitoring and management of residents finances.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Camphill Community Dunshane OSV-0003616

Inspection ID: MON-0025737

Date of inspection: 18/12/2018

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review has taken place in relation to risk assessments and supports needs as identified in support plans. A two-stage review of staffing and finances is in place. The first stage has been completed November 2018. The second stage of the review will take place in mid-March 2019. The purpose of the review is to identify the correct staffing levels in relation to support needs of each resident. Following the implementation of a new recruitment policy by Camphill Communities of Ireland, Dunshane Community will apply to the National Recruitment Panel for permission to recruit the identified new support staff. These posts will be assigned to areas where there is an increase in support needs and to mitigate the associated risk.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Previous to the unannounced inspection, a new management system was discussed in order to ensure that the service provided is safe, appropriate to residents needs, consistent and effectively monitored. This new management system was discussed and approved by the Management Team in December 2018, to be rolled out in January 2019. The new management system consists of increased oversight by the management team. This will be achieved by two members of the management team being present for weekly welfare meetings where all incidents that occur in the community are discussed and risk assessed. The community Health and Safety Officer will also be in attendance for this section of the welfare in order to assist with risk management. The weekly checklist which includes a section on health and safety will be copied to the H&S officer when sent to the PiC. Following on from the weekly Welfare Meeting, all incidents will be entered into a graphing tool to allow for visual tracking of trends and presented at Management meetings every second week in order to allow for greater oversight and efficient	

monitoring. This forms part of a concise system which will allow for the management team to quickly identify any trends occurring in the center and react appropriately in such cases.

All welfare and management minutes will be reviewed on a weekly basis by the designated centers regional manager.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
As part of an internal review of risk management processes following on from the inspection of the designated centre, it was observed that improvements could be made in the correlation of risk management pertaining to accidents and incidents within the designated centre.

Following the implementation of the designated centre's new management system, there has been a renewed focus on the connection between risk management of accidents and incidents. This comes in the form of a new process whereby the Health and Safety officer will attend all weekly welfare meetings where incidents and accidents are discussed. The Health and Safety officer will log all incidents in the general risk register after discussion with the Safeguarding and Complaints Officer. The new logging system will be available on a shared drive with access granted to all relevant parties to allow for greater oversight.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
There has been a considerable improvement in relation to access to multidisciplinary supports available in the designated centre. The centre has fully implemented Studio III as a behavioural management system and secured funding for clinical psychologist input in the form of a monthly clinic. The centre recently addressed the short period where clinical input by Studio III was not available. A clinical review day has been set for February 8th, 2019 with residents being seen in order of assessed need. In instances where clinical input cannot be sourced on the public health system, private clinical input has been sourced.

The national team have recruited a Clinical lead, this person will link in with the PiC and review all clinical supports within the designated centre.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Camphill Community Dunshane has stringent measures in place in order to significantly reduce the likelihood of financial abuse taking place. All residents' finances are audited monthly with oversight from the PiC, any anomalies, however small are investigated by

the PiC / DPiC. The community has recently introduced weekly check-lists from house coordinators to the PiC / DPiC which requires a weekly spot check on a residents finances. The community has also introduced Money Management Plans for all residents, detailing how financial transactions should take place and addresses any individual supports required to successfully manage their money. The plan also addresses individual risk and details on how to reduce this risk for each resident. The approach to risk management supports responsible risk taking.
A review of risk assessments and feedback following our inspection highlighted weakness pertaining to difficulties in accessing bank statements for some of the residents in the designated centre. Due to residents finances being primarily managed by families, the designated centre has organised a family forum day on February 7th to discuss this matter with families. An independent advocate from Sage Advocacy has agreed to discuss the assisted decision making act with a strong emphasis on residents finances and how families can support the resident and the designated centre in reducing the likelihood of financial abuse. Monthly checks will be carried out on all statements in relation to expenditure records kept in the centre, records will be cross check to ensure all expenditure is accounted for. Monthly audits will be conducted by the community admin assistant of all records to ensure they are being carried out effectively. Any anomalies will be investigated by the PiC/DPiC.

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.	Not Compliant	Orange	30/04/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	21/01/2019
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	Yellow	31/01/2019
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the	Not Compliant	Orange	07/02/2019

	personal planning process.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	01/04/2019