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 Jerpoint
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	26 June 2018
Centre ID:	OSV-0003624
Fieldwork ID:	MON-0021814

About the designated centre

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

The service is described as offering long term residential care to 11 adults, both male and female with intellectual disability, autism sensory and physical support needs. It comprises three houses each accommodating between two and four residents in a rural and tranquil setting with a working farm and gardens. The houses are suitable for purpose, well maintained and have all the facilities required to meet the needs of the residents. There are various workshops for crafts and cooking on site. Residents also access external day services or training in the wider community.

The following information outlines some additional data on this centre.

Current registration end date:	08/11/2018
Number of residents on the date of inspection:	10

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
26 June 2018	10:00hrs to 19:30hrs	Noelene Dowling	Lead

Views of people who use the service

The inspector met with six residents and spoke with three and also met with some family members. Residents completed questionnaires in some instances supported by staff or family members. All of the residents said that they were very happy with their lives in the centre , they said that they had good support from staff ,they enjoyed their various activities both within and outside the centre and were busy.They said they were in some instances making plans for changes to their living arrangements.

Family members were also very complimentary about the care they received, they described very good communication, consultation and said that they were confidant that their family member was happy living in the centre. They could raise any issues and they would be listened to , and had a good good quality of life.

Capacity and capability

The inspector found that this was a well-managed centre with good structures and levels of accountability evident which supported residents well being and development.

There were effective and improved systems in place for monitoring of care and evidence of responding to and planning for the residents future needs.

The provider and person in charge had satisfactorily addressed the 13 actions required following the previous inspection and these were seen to have a beneficial impact on the service provided to residents. These included improvements in behaviour supports, safeguarding, access to relevant assessments, staff supports and supervision all of which were of benefit to the residents wellbeing and safety.

There were effective quality assurance systems including robust audits of accidents and incidents, medicines administration systems, and staff training needs. Actions identified were seen to have been addressed by the person in charge. The governance and staffing arrangements had changed to provide better oversight and accountability with employed qualified staff as house co-coordinators with specific areas of responsibility identified. Inspectors saw that there were effective reporting systems evident which focused on residents care and support needs and any incident which had occurred,

There was evidence of increased oversight and monitoring by the senior management with weekly detailed reports forwarded.

The provider had made improvements in staffing the centre. The model of staffing in the centre was changing with an increase in paid qualified employees and a reduction in the number of short term co-workers and a small number of long term co workers. There were sufficient staff with the training and skills to support

residents with a significant ratio of one to one supports made available in accordance with their assessed needs. This did pose challenges for the provider in terms of resources, however it was managed well.

The young volunteers were also better supported by this systems with less overt responsibility on them for delivery of care but with defined duties, rosters and back up supports. The intake of the volunteers was also staggered to avoid unnecessary distress to the residents. There were employed staff in the individual units at all times.

While the specific roles of the volunteers was still under review by the provider nationally there were definitive rules governing their off duty behaviour and accommodation.

The provider demonstrated good capacity in relation to the recruitment, vetting and training of staff. Recruitment procedures were satisfactory with all of the required documents and checks being completed. Garda Síochána Vetting had been renewed for a number of staff. Supervision systems had also improved with regular formal systems being undertaken. The content was seen to be focused on residents care, staff development and accountability. There was also a much improved process evident for managing any issues which arose regarding staff actions or behaviours.

All mandatory training had been undertaken or was being updated. Staff had also received training in an additional behaviour support model deemed to be more suitable to the needs of the residents with one staff now trained to deliver this.

There was some evidence of good monitoring and audit systems in place. There were unannounced inspections undertaken on behalf of the provider and the annual report was available. However the content of both required review to adequately capture, report on and plan for needs of the residents. The views of both residents and families were ascertained and reflected positively reflected in the report.

Audits were focused on improvements for residents. A system of reviewing specific aspects of the service in the houses had commenced internally.For example, a recent review of residents' rights had identified issues such as the need for improved signage for those residents who could not directly communicate. This was being addressed.

All staff and the managers demonstrated a commitment to residents care and best interests and a satisfactory understanding of the regulatory responsibilities.

The statement of purpose clearly defined the service to be provided with care, support and admission processes seen to be managed according to this statement. This was a key governance document which ensured that resident's needs could be met in the service.

Staff and managers were seen to be very familiar with the residents' needs and preferences and fully engaged with them.

The provider had systems in place to listen to feedback and review how residents experienced the service. Complaints were recorded and monitored and seen to be managed in a timely manner. From a review of the incident reports, it was evident that the person in charge was forwarding the required notifications to HIQA and that actions taken in relation to these were appropriate and responsive. All residents had a contract for service which detailed all costs.

The documentation required for the renewal of the registration of the centre were forwarded in a timely manner

Registration Regulation 5: Application for registration or renewal of registration

The documentation and details required for the renewal of the registration of the centre was provided.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was suitably qualified, experienced and fully engaged in the role.

Judgment: Compliant

Regulation 15: Staffing

The staff number and skill mix of staff was appropriate to meet the needs of the residents.The roles of the volunteers was under review and they were supervised by the employed staff.

Judgment: Compliant

Regulation 16: Training and staff development

There was a commitment mandatory training and staff also had professional qualifications pertinent to the residents needs.

Judgment: Compliant

Regulation 22: Insurance

Evidence of insurance was provided and this was satisfactory

Judgment: Compliant

Regulation 23: Governance and management

The governance and monitoring structures were effective to provide good oversight and monitoring of practices.

The content and details of the unannounced inspection and the annual report however required some improvement to provide a transparent overview of the service which would support ongoing development.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose contained the required information and care practices were seen to be in accordance with this statement .

Judgment: Compliant

Regulation 30: Volunteers

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was found to be compliant in forwarding the required notifications to HIQA

Judgment: Compliant

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

There are arrangements in place fo the absence of the person in charge

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were acknowledged and managed in timely manner.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policy on the management of behaviours and restrictive practices required review.

Judgment: Substantially compliant

Quality and safety

The inspector found that residents had a good quality of life with meaningful activities, work and access to the community based on their individual needs and their expressed preferences which were responded to.

While residents capacity to communicate differed significantly systems for consultation were evident which took account of this. Staff were seen to be attentive to the residents non verbal communication and this was responded to in terms of flexibility of their personal routines on any given day. This had a positive impact on their quality of life. This was also detailed in their personal plans which guided staff to provide consistent care. Speech and language assessments had been sourced to help residents better communicate and staff to support this. Advocates had been sourced to help residents with specific decision making and one resident had joined the local HSE advocacy group.

Since the previous inspection increased access had been made available to additional psychology, behaviour supports and sensory assessments for a number of residents who required this. Further referrals had been made for other residents.

Support plans were implemented and in once instance a full review was being undertaken to implement the strategies outlined by the various assessments.

The person in charge was in the process of making alternative living and support arrangements for one resident based on the residents assessment and expressed wish for a semi in dependant/ supported life style. The resident was fully involved in the accommodation decisions and transition planning. Plans were also made to alter the accommodation within the centre for three other residents to provide more personal space and separation of residents which was necessary and appropriate to their individual needs.

Residents had had frequent multidisciplinary reviews of their health and psycho social care needs undertaken in consultation with the residents and family as appropriate. These were detailed and comprehensive.

Support plans were implemented and further plans and goals identified. However , the details of how the plans would be implemented were not always recorded. There was evidence from other records and from speaking with staff and residents that this was a documentary deficit only and residents' individual goals , such as holidays were being achieved with good supports from staff.

Resident's varied and complex healthcare needs were promptly noted, responded to and monitored. Inspectors saw that staff supported the residents themselves to be informed and to take control of these where this was possible. Dietary needs were known by staff and where necessary up to date speech and language assessment had been undertaken and the support plans were being adhered to.The food was freshly cooked and of good standard.

Residents had good access to the local communities for recreation work or development. These included art and exhibitions, drama libraries , swimming, therapeutic horse riding, massage and local festivals. They had easy access to the other houses for socialising if they wished. The external environment provided easy access to the animals and the farm land which was tranquil and suited the needs of some residents very well.

Risk management systems had improved with a more detailed risk register , to include clinical and environmental risks and evidence of actions taken to address risks. There were detailed and pertinent risk assessment and management plans for each individual resident however including falls risks , health care , diet and personal safety.

All of the required fire safety management equipment including containment doors were present and serviced as required. Staff diligently undertook regular drills with residents and any problems identified with evacuation were addressed .Residents personal evacuation plans had been amended to include the specific requirements necessary to support individual residents in such an event.

Works had been undertaken in one house on upgrading the fire safety management systems. In addition, the person in charge was acting on a recommendation made

by the health and safety consultant in regard to a lighted exit sign for one area.

There was a noticeable improvement evident in the systems for recognising, responding to and reporting abusive interactions which led to increased protection for the residents. In addition to the training for staff the provider had engaged a qualified person with experience to oversee and manage such incidents. This had resulted in a more robust and effective response for both those residents who were impacted by the actions and those who were responsible for them if inadvertently. This also included better management protocols for the manage of statements made by residents which may have been indicative of abusive interactions or unmet needs.

In addition, inspectors found that staff were adhering to their responsibility to report the actions of colleagues if these were deemed not appropriate to the residents. These resulted in a robust and transparent trust in care process ,followed by close internal and external review to ascertain if the failings were understood and therefore less likely to reoccur.

There was also improved clinical guidance for the support of behaviours that challenge. Detailed support plans were implemented and overseen by clinical specialists to promote the best outcome and reduction in behaviours for the residents. There was a lack of clarity and agreement noted in records for decision regarding the issue of medicines for the support of behaviours. This required coordination of clinical input by those external clinicians concerned to best guide staff.

In two instances the environment was noted by clinicians as having a negative impact on behaviours and thereby on other residents. The centre was responding to this advice however there was a negative impact on some residents as this matter had not been resolved in a timely way. Plans were being made in one instance to address this. There was evidence of repeated efforts at the local level by the person in charge to access funding to allow a change of living environment within the centre for one fo the residents. This had not progressed to a sufficient degree at the time of the inspection.

The provider had increased staffing support significantly to address this on an interim basis. However, a significant number of incidents were seen to be still occurring .These impacted on other residents and on the residents concerned wellbeing. This was an area which required to be addressed.

Resident managed their money with the appropriate level of staff support an there was systems for oversight of this. However, the inspector noted two areas where further oversight was required but these were under the remit of the provider.

These were discussed with the person in charge who was aware of the issue and agreed to seek external guidance on them to ensure resident's best interest were protected.

Medicines management systems had been fully reviewed in 2018 and all findings had been addressed to ensure the safe administration of medicines.

However on this occasion there were no protocols for the administration of some PRN (administer as required) medicines. This requried review in order to ensure consistent administration of these medicines. Although no concerns were noted by inspectors in the issue of these. All errors were promptly and addressed satisfactorily.

Regulation 10: Communication

The we re good systems to support residents to communicate and their needs were detailed in the support plans.

Judgment: Compliant

Regulation 13: General welfare and development

Care was taken to support residents preferences and capacity in relation to training , work and life skill development.

Judgment: Compliant

Regulation 17: Premises

The premises and grounds were well maintained, comfortable and suitable to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management systems were pro-active responsive and proportionate which to the needs identified..

Judgment: Compliant

Regulation 27: Protection against infection

There were systems for the management of infection which took the location of the centre into account as well the individual needs of the residents.

Judgment: Compliant

Regulation 28: Fire precautions

Good fire safety management systems were implemented and monitored.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Protocols for the use of some low risk PRN (as required) medicines were not in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was good access to multidisciplinary assessment and residents were for the most part well supported to lead interesting lives.

However, it was apparent that the centre was not meeting the needs of one resident. This needed to be addressed.

The documented guidance in some personal plans required improvement.

Judgment: Not compliant

Regulation 6: Health care

Residents healthcare needs were identified , monitored and responded to in a timely manner.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours with specialist clinical assessment and guidance for staff ;

Restrictive practices were assessed , monitored and used for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Systems for the protection of vulnerable adults and responding to concerns for residents were robust and responsive and monitored..

Judgment: Compliant

Regulation 9: Residents' rights

Resident rights were promoted and there were further plans evident to improve this by ensuring they were aware of and had access to external supports.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Jerpoint OSV-0003624

Inspection ID: MON-0021814

Date of inspection: 26/06/2018

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 act 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 act *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 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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: *The Person nominated by the registered provider has agreed a schedule of visits for the coming year, these have been agreed by both the PIC and the nominee and will include an unannounced visit.* *The written reports will summarize/ evaluate findings detailing any actions regarding concerns highlighted. All relevant areas covering the standards will be assessed and a schedule of actions agreed. The plan will be **SMART** and will clearly state actions for implementation within definitive timelines.*	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: *Policies highlighted in the inspection report have been addressed and include the Positive behavioral support policy and the Children's first policy, both amended policies have been drafted and will be reviewed at the Collaborative learning group on August 8th.* *The policies will be signed off at the forthcoming Directors meeting by August 20th.* *Both policies with changes will be implemented in the communities by August the 30th.*	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and	

pharmaceutical services:

The collaboration between Neurologist / GP / Psychiatrist re medication changes for one resident has been followed and MDT conversations have informed the timeline re prescriptions and incremental changes issued by GP. This has been evidenced since the inspection and a letter outlining planned changes from the GP has been forwarded to the PIC on request.

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:

Concerns regarding a resident's placement have escalated, these concerns are mainly to do with safeguarding issues which cannot be adequately dealt with due to a grossly under resourced placement.
The Resident has had a termination notice issued on three occasions since 03/03/17 due to Safeguarding issues which we were unable to manage due to underfunding. The termination notices were withdrawn at the request of the HSE Area 7.
The final termination has been sent in on the 30/08/18 and Family/ Resident/ Advocate / HSE have been informed.
A transition meeting is planned with HSE / Family advocate/ CCOI Personnel and the resident on August 8th.
A Safeguarding plan is in place for all affected residents in the household and an interim transition plan drawn up for the resident.
Termination of placement is planned for August 30th.
Additional staff have been put in place to reduce risks and manage the household in the coming weeks until the placement is concluded.

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 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.	Substantially Compliant	Yellow	30/08/18]
Regulation 29(2)	The person in charge shall facilitate a pharmacist made available under paragraph (1) in	Substantially Compliant	Yellow	08/08/18 completed

	meeting his or her obligations to the resident under any relevant legislation or guidance issued by the Pharmaceutical Society of Ireland. The person in charge shall provide appropriate support for the resident if required, in his/her dealings with the pharmacist.			
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	Implementation across all communities by 30/08/18
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	[30/08/18 Termination of placement