Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of designated centre: | Camphill Community Kyle |
| Name of provider: | Camphill Communities of Ireland |
| Address of centre: | Kilkenny |
| Type of inspection: | Unannounced |
| Date of inspection: | 21 November 2018 |
| Centre ID: | OSV-0003625 |
| Fieldwork ID: | MON-0025277 |

## 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 to 17 adult residents, male and female a with intellectual and physical disability, autism, and challenging behaviours. Nursing oversight is provided on a part time basis. The centre is located in rural setting and comprises of six units accommodating between one and five residents.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 16 |

## 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 |
|---|---|---|---|
| 21 November 2018 | 09:00hrs to 19:00hrs | Noelene Dowling | Lead |
| 21 November 2018 | 09:00hrs to 19:00hrs | Conor Dennehy | Support |

## Views of people who use the service

Inspectors met with four residents and spoke with two. Other residents allowed the inspectors to observe some of their routines and activities and others were busy at their various work. Residents who could communicate with the inspectors stated that they were currently happy and felt safe and enjoyed getting out and about to their activities and routines, and getting to their medical appointments. They said staff were helping them with their exercises and this was making a difference to their mobility.

## Capacity and capability

This was the seventh inspection of this centre which was granted registration on 8 August 2018.

This inspection was undertaken as a result of solicited and unsolicited information received from a number of sources, including the provider, regarding the safeguarding of residents. HIQA had sought various assurances from the provider in regard to this. In view of the nature of the information this inspection focused on the substantive areas of governance, safeguarding and staffing.

The findings of this inspection indicate that the governance systems were not satisfactory to ensure the service was safe and effective.

This inspection found a deterioration in a number of areas since the previous inspection in April 2018. It is acknowledged that the issues presented were complex. A number of factors contributed to this. There was, and had been, a high degree of disruption and lack of stable and cohesive management in the centre. The provider had been unable to secure and then retain a full time dedicated person in charge. This was a requirement of the previous inspection. At the time of this inspection the post holder appointed on 8th October 2018 had already resigned and was only available two days per week which did not provide sufficient oversight. This was also compounded by changes to other local managers.

A number of the findings in relation to safeguarding, behavioural supports and incident management demonstrated the direct impact and risk of this to residents care. This was despite the obvious best efforts of all concerned. Staff advised the inspector that this lack of stability and consistency was impacting on their ability to provide care and supports in a consistent manner. These matters are outlined in more detail in the quality section of this report.

Procedures for quality assurances were not robust with evidence of inconsistent

review and response to incidents of challenging behaviours or risks to residents evident. Inspectors were informed that a full service review was being undertaken nationally which is a positive undertaking. However, in respect of this centre the systems including the providers unannounced inspection report was limited in scope and failed to reflect or plan for the issues which impacted on the centre.

There had been a significant staffing crisis in the summer. The number of staff had significantly increased since then which had stabilised the situation. Parents who met with inspectors cited the positive difference to the residents care this had made.The use and dependency on short term co-workers had also reduced. The arrangements agreed with HIQA for the co-workers to live in separate accommodation and have scheduled time off had also been implemented. Recruitment procedures were mostly satisfactory but there were a number of significant gaps noted on some staff files provided which had not been clarified

However, given the events which had occurred and been identified in the centre it was of significant concern to HIQA that formal staff supervision systems had not been sufficiently implemented to ensure residents care was delivered in a safe and appropriate manner.

There was an improvement in complaint management with evidence that issues were managed in a more transparent and responsive manner.

## Regulation 14: Persons in charge

The arrangements for the role of person in charge were not satisfactory. The person in charge at the time of the inspection was not employed full time in the centre and there was no adequate oversight arrangement in place.

Judgment: Not compliant

## Regulation 15: Staffing

While the numbers of staff were satisfactory the provider did not have safe and effective recruitment procedures in place.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There was no effective supervision systems in place for staff.

Judgment: Not compliant

## Regulation 23: Governance and management

Management structures and arrangements did not provide for adequate oversight, monitoring and direction of care practices to ensure they were safe and suitable to meet the residents needs.

Quality assurance systems were not robust or consistent and no adequate review or inspection of the quality and safety of care was undertaken by the provider.

Staff were not managed in a manner so as to ensure they
took professional responsibility for the safety of the services they delivered.

Judgment: Not compliant

## Regulation 31: Notification of incidents

A number of significant incidents had not been reported to HIQA in line with regulatory requirements.This has been rectified retrospectively.

Judgment: Not compliant

## Regulation 34: Complaints procedure

There was an improvement noted in the timing and transparency with

which complaints were managed.

Judgment: Compliant

## Quality and safety

Inspectors found that there were still improvements required to ensure that the residents received a consistently safe and effective service based on their individual assessed needs. This affected their safety and overall well-being. Some of the residents care needs continued to be well supported with good access to chosen activities and social events and health care. The increase in stable staffing and in some instances one to one supports had greatly enhanced this for the residents. Inspectors observed residents being busy and active in their routines and engaging easily with staff. Staff advised that the recent training in a revised model of managing behaviours that challenged had been extremely helpful to them and they were implementing this which in some instances had significantly reduced incidents.

However, this was not a consistent finding. A number of concerns were noted by inspectors for individual residents. There was a lack of support or safeguarding plans implemented and referral to mental health specialists were not made available when this was necessary. There had been an increases in some behaviours such such as self-harm and aggression and a number of incidents of sexualised behaviours had occurred on a number of occasions. Staff were not aware of the risks either of self harm or suicidal ideation due to a lack of communication in one instance. Where clinical expertise had been available there was a lack of routine feedback, records of meetings or guidance for staff to enable them to support the residents effectively and respond to behaviours of concern.

It was also of concern that inspectors were informed by staff that they were directed not to document the specific behaviours or concern presented by a resident in any support plan or risk assessment. The rationale provided to staff, as told to the inspectors, demonstrated poor understanding of the required response to the management of this behaviour which placed the resident at risk. The managers were unable to provide any explanation as to why this occurred.

The management of a number of other safeguarding issues relating to the behaviour of staff was also of concern and did not demonstrate clarity of responsibilities in regard to these .In June 2018, the designated officer and senior manager informed HIQA that a review of a resident's daily records and files had revealed unacceptable and punitive practices in the actions taken to manage the behaviours of one resident. These details spanned a time frame from 2013 to 2016. This was promptly reported to the HSE and HIQA.

At that time the provider was requested to provide assurance to HIQA that the matter was being addressed and residents in this centre and others in the

providers communities were not subjected to this by persons still involved. A scoping process was undertaken by the provider but this was not part of a direct safeguarding or trust in care process.

The provider also commissioned a comprehensive independent review of all residents' records to ascertain if these practices had been widespread and current risks. This review unearthed a significant number of other such incidents and involved a number of other vulnerable residents.The nature of the actions included deprivation or threats of deprivation of basic needs such as tea, or favourite foods, and activities and throwing a resident's ice cream in the bin.

The independent report identified 11 outstanding matters following this review which had not been reported or acted upon. Some outstanding actions in relation to reporting to the HSE, finalising safeguarding plans and dealing with persons currently working in other centres in the organisation remain outstanding following these reviews. It is acknowledged that the most recent incident dated October 2018 was promptly reported by staff and the remainder were duly notified to HIQA following the independent report.

These practices had been viewed as being heavily influenced by the culture in the organisation over a period of time. However, as a number of the incidents related to the same behaviours and actions taking place in 2017 and 2018 and were clearly recorded and available to view this cannot fully explain the incidents.

Despite the very positive intervention of commissioning the independent review a number of actions and decisions taken by the provider in relation to these current matters remains of concern. The provider failed to ensure the residents current safety when known issues arose and in the screening process. The inspector was informed that these decisions were made due to staff shortages.

The reports made additional recommendations including staff training in behaviour supports, safeguarding and report writing in terms of the language used to reflect a more respectful view of the residents. These have been agreed and commenced by the provider.

However, all documents seen in relation to these matters cited the providers assurance that ongoing and regular supervision of staff was being undertaken to ensure such incidents do not reoccur. This was not the finding of this inspection. This and the lack of consistent and appropriate management oversight remains a risk to the residents ongoing welfare.

## Regulation 26: Risk management procedures

Significant risks to residents including self harm were not addressed, responded to or planned for adequately.

Judgment: Not compliant

## Regulation 7: Positive behavioural support

Systems available for supporting residents with behaviours that challenge did not provide sufficient direction or guidance for staff in managing such incidents. Evidence demonstrates that despite the additional training available to staff, further intervention is needed to ensure that supports used are appropriate and safe.

Judgment: Not compliant

## Regulation 8: Protection

Residents were exposed to unsafe and unacceptable practices implemented by staff. Actions were not taken when these practices were known in the recent time periods. Actions taken were not timely and did not afford sufficient protection to residents. A number of incidents were not investigated.

Judgment: Not compliant

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Not compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Not compliant |

# Compliance Plan for Camphill Community Kyle OSV-0003625

## Inspection ID: MON-0025277

## Date of inspection: 21/11/2018

**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 14: Persons in charge | Not Compliant |

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
14.1 It is acknowledged that retention of PIC has been an issue for Kyle. The PIC role is central to consistency, stability and leading change in a community. The history of change in the role of PIC has diminished the effectiveness of the service to embed and sustain change and develop confidence and culture in positive practice as identified in previous actions plans.
The two deputy PICs who supported the exiting PIC have also resigned their posts (exiting dates 21/12/2018 and 25/01/2019). The role of all three is acknowledged and they exit in a planned way giving detailed handover and assessment of the issues from their local knowledge, and from their particular roles and responsibilities. All three are committed to being available to the new management team at Kyle for additional information and input if required.
The regional manager for Kyle has also recently resigned from post.

A new full time PIC has been recruited and appointed commencing on 17/12/2018. The PIC comes to the post from within Camphill, is fully aware of the challenges and the opportunity for Kyle and is ambitious to lead the changes that are required to bring Kyle to a point of stability and to lead on going service improvements.

A regional manager from within Camphill has been assigned to the regional support and oversight role to the community and PIC
Action completed 17/12/2018
14.2 Recruitment has commenced for a Deputy PIC and a Social Care Coordinator as key roles reporting to the PIC. Both new posts to be in place by 21/03/2019
14.3 Support and oversight to the PIC will be via the regional manager through weekly presence in Kyle, participation in local management team, weekly PIC to RM checklist system, oversight of all safeguarding issues that arise. Additional support on service planning, operational and financial management, and HR will be provided by other members of the Senior Management Team including on site presence in support of the

PIC role – in place since 07/12/2018.

14.4 Camphill has appointed an experienced National Safeguarding DO as an additional resource to safeguarding project work in 2019. This person will support the PIC in the DO Safeguarding role until new posts are filled within Kyle – Additional Safeguarding Support commencing from 07/01/2019.

| Regulation 15: Staffing | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 15: Staffing:
PIC with HR manager Camphill will audit existing HR management system and processes.
15.1 Identify non-compliances with policy applying to recruitment, appointment, induction, probation, supervision and appraisal procedures and put corrective measures in place. 01/02/2019
15.2 Identify any deficits in HR files and rectify with assistance from national HR manager 31/03/2019
15.3 Recruitment checklist has been created in accordance with Regulation to ensure that a safe and effective recruitment procedures are existing in Kyle. This will be in practice from 01/01/2019.

| Regulation 16: Training and staff development | Not Compliant |
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:
16.1 Two full days of Supervision Training has been organized for all supervisors in Kyle. These two days of training will equip supervisors with the skills necessary to provide supervisions using the C.L.E.A.R. (Contract, Listen, Explore, Action & Review) model of Supervision which was developed by Hawkins and Shohet and linked to the reflective Cycle -Kolb.
This training will outline the four functions of the supervision process which are: Administrative, Educative, Supportive & Mediative. It will highlight the legal and regulatory role of regular and effective supervision.
This supervision training is working within Camphill's Supervision & Appraisal Policy, which will provide consistency and oversight of the supervision process. Completion 11/01/2019.

16.2 PIC will provide support for supervisors and oversight of their supervisions to ensure supervisions are of a professional quality. Completion 12/04/2019

16.3 In December 2018 a supervision schedule was created to plan and monitor supervisions. The PIC will audit compliance with this schedule quarterly and report as an service KPI . Completed 01/01/2019

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| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23.1 Rostering that ensures on site management / supervisory presence for 7 days a week by either a PIC, and House Coordinators or member of the Welfare Management Team until such time that the posts at 14.2 are recruited. There will be an identified duty manager for 'in time' response and support to arising care needs of residents. Commenced 7/01/2019
23.2 'In Time Response': A daily reporting procedure will be introduced to communicate where care issues / emergent concerns arise and will be notified from each unit to the PIC / Duty Manager on the day. They will be actioned by the PIC / duty manager on the day and reviewed at weekly Welfare meetings. Introduce 08/02/2019
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23.3 Weekly Welfare Meeting are held including PIC, Health and Safety Representative, and House Coordinators (care managers). Regional Manager to review TOR of Welfare group with PIC. Minutes of both Management Team and Welfare Group are circulated to Regional Manager.
23.4 Weekly Checklists from House Co-ordinators to PIC are generated and a summative weekly checklist from PIC to RM (using revised versions from CLG November 2018) will be introduced from 11/01/2019
23.5 Communications and Availability: PIC spending time in each designated center and being accessible to Residents and all team members.PIC (D.PIC) attending Short Term Co-workers meetings at least once a month.
PIC (D.PIC) attending Team Meetings in each house at least once a month.
Minutes of all team meetings forwarded to PIC. Commenced 17/12/2018
23.6 Professional Responsibility: Training on Code of Conduct and Performance Improvement Plan/Disciplinary procedures to be implemented as required.
Appraisal Schedule to be created, information on this will be incorporated in the Supervision training on the 10 & 11th January 2019. Appraisals will be performed in line with Policy where a senior member of management and direct manager will annually review an employee's performance and create an action-based plan with the employee to improve their performance.

Weekly Key-working sessions with Residents are planned and will take place commencing February 2019, all managers will support Residents to appoint a team member of their choice to meet and document the Residents' preferred choices, feedback and concerns. HC will read and sign these key-working sessions. Any concerns

arising from these Key-working sessions will be communicated to PIC.

Staff supervision process will focus on individuals taking "professional responsibility for the safety of the services they deliver". Emphasis on this will form part of the training for supervisors January 10 and 11th inst. - the emphasis becoming a focal point of the supervision sessions. Overview of the quality of supervisions process will be established by the PIC and RM via a two qualitative review and feedback on the supervision process and its capture of responsiveness to care and support needs and personal goals of residents. First qualitative review completed 26/04/2019
23.7 Quality Assurance Oversight and Review by Provider: The engagement and oversight role of the RM and other members of Camphill Senior Management Team are noted in points above.
The key regional manager oversight actions of on site engagement weekly, inclusion in circulation of management and welfare team meetings / minutes, weekly checklist (report) Pic to RM and inclusion in all safeguarding incidents have commenced 01/01/2019.
23.8 The RM will draft a Quality Improvement Plan (QIP) based on the two last HIQA inspections and the arising compliance plan 2018 and current 2019. This plan will be reviewed and revised reflective of progress on implementation, new issues that arise, feedback from engagement with residents, families and other key stakeholders and an unannounced provider inspection in April 2019
Quality Improvement Plan 11/05/2019
Unannounced Inspection and revised QIP 15/11/2019

23.9 The national Quality and Safety lead CCOI will review all Kyle registers on a weekly basis and advise RM and PIC on any trends, errors or queries that need clarification, attention or action. Commenced 05/01/2019
23.10 The Q&S Lead will work with the RM and PIC in developing the QIP and will incorporate learning / systems / process review to enhance quality and safety of care. This will include inclusion of Kyle in the current LEAN Project on Safeguarding process improvement in CCoI.

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
31.1 Safeguarding Awareness : A Review of understanding, attitudes, reporting knowledge and practice was undertaken by members of the SMT in Kyle. A target audit of safeguarding practice by members of Camphill SMT was undertaken December 13 2018 to 4 January 2019 . The meetings with front line and supervisory staff reviewed understanding, attitude, reporting and practices on safeguarding. The outcome of the audit is that further training and focused supervision is required to ensure full understanding of zero tolerance and appropriate reporting and follow up action on safeguarding concerns. Reference Chief Operations Manager Report completed

04/01/2019 and forwarded to Senior Management Team and Board of Directors CCOI. Completed 04/01/2019
31.2 Safeguarding Training: Training will take place in January/February 2019 at all Team meetings highlighting the regulation ref HIQA Reporting of Incidents/ Accidents/ Near Misses and Notifiable Events. This training will also inform all team members that a failure to follow protocol will result in a Performance Improvement Plan/Disciplinary Action. The HSE will assist training through one of their Safeguarding and Protection team members contributing to training with specific reference to zero tolerance; awareness of potential institutional abuses; creating a positive safeguarding culture, and reporting to HSE S&P team / using the consultative functions of the S&P team as a positive resource to enhancing Safeguarding practices and culture.
Completion date: 08/02/2019

31.3 A Full-time PIC In Designated Centre with overall responsibility for notifications. Commenced on the 17/12/18.
31.4 The Safety Officer role has been progressed to full time with scope to ensure capture of all incidents, accidents, near misses, BTC, safeguarding concerns to PIC. Safety officer will work with supervisors in reviewing risk assessments arising in care practice situations and in drafting revised risk assessments for review by Welfare Group. Commenced 21/01/2019
31.5 The PIC will carry the function of the Designated Officer for Safeguarding until a deputy with responsibility for DO is recruited. The PIC will be assisted in the DO role on an interim basis by an experienced safeguarding designated officer with a national safeguarding role and based locally in Camphill Carrick on Suir Completed 07/01/2019

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| Regulation 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
26.1 The PIC will oversee all House Coordinators in ensuring individual needs assessments are up to date and accurately reflect current needs; that current risk assessments are in place and that supporting actions to meet assessed needs and associated risks are addressed in residents PCPs. 28/03/2019
26.2 CCOI is introducing the Studio 3 as the preferred model of supporting people with behaviors that challenge. This is a low arousal and environmental accommodation approach to supporting people, keeping people safe and enhancing knowledge and understanding around specific issues and appropriate trained supportive approaches for individual residents. All staff will receive 3 day training and ongoing practice review. This will include incident review by in house 'trained trainers' in Studio 3 where such is required arising from incident review. Day one completed with all staff in December 2018. Completion of remaining training for all staff by 12/04/2019
26.3 Kyle has a significant number of residents with a diagnosis of ASD and residents with autistic features. To build on the Studio 3 approach and to broaden the

understanding by staff of communications and other environmental issues residents with ASD features the service will provide dedicated training to the staff team in Kyle. This will be bespoke and focus on particular communications issues and approaches for the particular residents of Kyle. Issues of understanding and approaches to sexualized behaviors also need knowledge and skills developed within the staff team. The CCOI national Quality and Safety Lead will deliver staff training and guidance on relationships and sexuality, bespoke intervention / guidance on case specific issues. This intervention may include the offer of relationships and sexuality information, training and support within PCPs for a number of residents where identified as an appropriate option.
Completion By 17/05/2019

26.4 In addition a number of residents have episodic or on going mental health issues. The service will work with the GP service and the HSE to have appropriate reviews undertaken which bring a multi disciplinary dimension to the review of peoples needs and which work in harmony with the trained approaches and emerging through the Studio 3 and autism awareness engagements. Completion by: 08/03/2019
26.5 The PIC will build on a review of all safeguarding plans recently conducted. A programme of review to ensure consistent understanding and application of the safeguarding plans of each individual will be lead out by the PIC in conjunction with the Welfare group and each House Team. The aim to ensure consistency of understanding and application in ensuring safety and quality of care, support, and opportunity for each person with a SG plan. This action will address and review specific issue of concern such as self harm, suicidal ideation and sexualized behavior. This action aims to ensure that clinical inputs and directions are known, understood, and, applied consistently within each house team. Completion date: 18/02/2019

26.6 Health and Safety Officer in conjunction with House Co-ordinators to ensure that all risk assessments and follow up from Challenging Behavior Incidents are carried out and are reflected in Care Plans, Behavioral Support Plans and Personal Plans. Health and Safety officer will conduct six monthly audits in respect of this action
Completion 28/06/2019

26.7 Safeguarding Issues arising from Wolfe and Internal Summative Reports.
A number of follow up actions are in train in respect of safeguarding issues. The issues of concern are reflective of poor care practice and associated cultural influences concerning approaches to managing behaviors / understanding the principle of zero tolerance / aversive Vs positive approaches to supporting behaviors of concern. Identifying all staff concerned be they within CCOI or in practice in other services is being actioned. A number of Trust in Care processes are also in train. Action has been taken to ensure no aversive approaches are in practice in Kyle at this time, this is being assured through ongoing training, oversight and audit.
Completion date all actions: 01/07/2019

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| Regulation 7: Positive behavioural support | Not Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
7.1 Review 3 Behavioural Support Plans per month starting January 2019. These will be reviewed by a Multi-Disciplinary Team, consisting of a Behavioural Specialist (external), Studio 3 Psychologist (if required), PIC, House Co-ordinator, SLT / communications specialist if applicable.
Informing the residents behavioural support plans will be ABC charts, Behaviour trackers, GP feedback, SLT care plans, Psychiatry notes, Psychology recommendations, TUSLA if applicable, Incident/Accident Audits, Risk Assessments, Family Feedback and Residents Choice.
Completion 28/06/2019

7.2 All supervisory level staff will complete the Callan Institute e-learning MEBS (Multi element behavioural support) course. This will be completed from a shared learning approach with the team of managers / supervisors working together to share and reflect on the core principles and values underpinning positive behaviour supports. The course is a well aligned fit for supervisors and managers in settings where Studio 3 is used as the trained approach for front line staff.
New Key-working template circulated and to be completed weekly with residents, providing space and time for each resident to reflect on the quality of their care in a person-centred format. This is to be signed off by PIC (deputy PIC) at welfare weekly.
Performance Improvement Plans to be discussed with local management at welfare meetings and then filtered to full staff team through mandatory Team Meetings. These will be implemented to address any deviation from Care Plans or Poor practice.
Completion 28/06/2019
7.3 Use of appropriate language and terminology. In house training has occurred on the 23/11/18 to address Report writing Skills. Completed 23/11/2018

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| Regulation 8: Protection | Not Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
8.1 The PIC, Regional Manager and Chief Operations Manager will have a regular presence in Kyle with a particular emphasis on observing practice and providing assurance to the SMT and the Board of CCOI that the actions and interventions outlined in this assurance plan are delivering safe and acceptable practices of care and support to residents. Observations will be supplemented by feedback from residents and their families / advocates on quality of care and support. This action will continue through 2019 as part of assuring a positive open culture of safeguarding care and support is

maintained and continues to evolve positively.
Completion 14/12/ 2019
8.2 The service will engage with input from members of the HSE Safeguarding and Protection team in coaching sessions on developing a positive safeguarding culture . This will be via an agenda item on team meetings in each house in Kyle with input from HSE members within the context of local provision for each house.
Completion 30/04/2019
8.3 HR / TIC actions will be continued or pursued in respect of any safeguarding concerns which involved staff members / co-workers where these have not been concluded. Completion: 28/06/2019
8.4 Safeguarding Assurance: CCOI is currently recruiting for a principal social worker for the role of National Safeguarding Lead with a role of leadership in assurance on best practice in safeguarding. Completion 11/03/2019
8.5 The national Quality and Safety lead currently reviews all incident, safeguarding, accident, near miss registers weekly, and the risk register for each community. Serious issues or trends of concern are reported at weekly SMT meeting. The Quality and Safety lead also emails RMs on issues where further clarification is needed and seeks clarity.
Completion 04/01/2019

## 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 14(2) | The post of person in charge shall be full-time and shall require 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. | Not Compliant | Orange | 07/01/2019 |
| 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 | 31/03/2019 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 12/04/2019 |
| Regulation | The registered | Not Compliant | | 15/11/2019 |

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| 23(1)(c) | 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. | | Orange | |
| 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 | 15/11/2019 |
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | Not Compliant | Orange | 15/11/2019 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the | Not Compliant | Orange | 01/07/2019 |

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| | designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | | | |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident. | Not Compliant | Orange | 08/02/2019 |
| Regulation 07(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour. | Not Compliant | Orange | 28/06/2019 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Not Compliant | Orange | 14/12/2019 |