Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Grangebeg Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	14 February 2019
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0026403

About the designated centre

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

Grangebeg Camphill Community has a statement of purpose in place highlighting that it is a residential service inspired by Christian ideals where people of all abilities, many with special needs, can live, learn and work with others in healthy social relationships based on mutual care respect and responsibility. The centre is a registered designated centre to provide residential services to up to 13 residents.

The following information outlines some additional data on this centre.

Current registration end date:	06/05/2020
Number of residents on the date of inspection:	10

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
14 February 2019	09:00hrs to 17:00hrs	Erin Clarke	Lead

Views of people who use the service

As this was an unannounced inspection, a number of residents had left for their workshops and so were unavailable to give their views however, the inspector had received 10 questionnaires from the residents and was able to meet with a few residents on their return. All of the residents appeared at ease in, and familiar with, the centre. They also appeared comfortable when in the company of staff. The inspector observed residents and noted the positive interactions that took place between residents and staff.

The questionnaires were filled in by residents themselves; and some were assisted with filling in the answers by staff and family members. There was a high level of satisfaction expressed about the support and care they received at the centre and comments were made about their happiness in relation to the staff, comfort of centre and access to gardening facilities and workshops. Of those who had made complaints, all were happy with how these had been addressed. One resident was complimentary of the changes that had occurred in the centre. Some residents identified extra activities and improvements to bedrooms and mealtimes which were discussed with the person in charge.

One resident was dissatisfied with their living situation and the provider had recognised this and was working with the resident to identify alternative arrangements.

Capacity and capability

The purpose of this inspection was to ensure that the provider had addressed the concerns raised in a warning letter from the Office of the Chief Inspector in May 2018, following an inspection of the centre. Overall it was found that the provider had made further progress on resolving these concerns since a follow up inspection in July 2018, which had included implementation of an overarching management system that was consistent and robust for the effective oversight of the designated centre.

It was clear during the inspection that the governance and management arrangements had been strengthened since the previous inspection with the establishment of new national posts. A new Chief Executive Officer (CEO) had been appointed along with a Chief Financial Officer, a human resources manager, operations manager, a quality and safety lead and clinical lead. A financial and operational review was currently underway in all Camphill Community services to provide rationale for; and a baseline of support resources and associated costs

required to provide for the needs of residents. This was due for completion by the end of March, this review was significant as the person in charge and management team cited funding and staffing levels as the biggest challenge and risk that the centre faced.

Although the staffing whole time equivalence (WTE) deficit had improved since the previous inspection, there still remained two WTE vacancies despite recent recruitment. It was noted that there was a significant reduction on the reliance of agency workers to fulfil shifts due to the increase of staffing levels. However from a review of house rosters and speaking with staff and management it was evident that some residents required higher levels of support of 1:1 ratio with staff that were not currently funded for but the person in charge strived to cover for within the current pool of staff. This was further impacted by the requirement of some residents requiring 2:1 support whilst away from the centre. This limited the opportunity of participating in individual activities outside of the designated centre. One such activity had been cancelled for one resident during the inspection due to inadequate staffing levels. Staff recruitment practices had improved since the previous inspection regarding the use of agency staff. The person in charge had ensured a system was in place for the oversight of agency staff personnel files as set out under Schedule 2 of the regulations.

The provider had agreed not to admit further residents following the warning letter due to inappropriate admissions that were not based on clear and comprehensive assessment and were furthermore not matched with the centre's statement of purpose in terms of the service that could be provided. It was evident from this inspection that the current management team were prioritising the care and welfare of the current residents and ensuring appropriate staffing levels before admission of further residents. Additionally at a national level the admissions and discharge policy was currently under review to ensure that admissions are managed through a nationally agreed procedure. Stakeholder meetings with family and advocate representatives were held in November 2018 to review the contract of care in line with the admissions process and statement of purpose.

The formation of the national working groups were still in their infancy with terms of reference being currently developed but the inspector was informed that the key focus of the clinical team would be behavioural supports approach and delivery in services. An education and training working group was also being developed that would review medication management, intimate care planning, support plan and assessments development. The provider had also advertised for a national Safeguarding Officer role that would oversee all safeguarding concerns.

The provider had assured operational oversight of the designated centre through the development of weekly incident registers which were reported to the senior management team. The person in charge was supported by a regional manager and there was evidence of monthly collaborative meetings between all persons in charge, senior management and the CEO for shared learning and update on organisational review. The provider had assured that six monthly unannounced visits had occurred and reports were available to the inspector to review, the latest unannounced visit from November 2018 was reflective of the issues that the

inspector identified on the day of inspection.

The inspector viewed a number of audits that had taken place and found that these were proactive and identified a number of areas for improvement with corresponding action plans, dates for completion and persons responsible. Whilst there were gaps identified, for example in the frequency of supervision meetings and residents' personal plans content, these were identified by the person in charge and action had commenced to ensure full compliance.

A clear training needs planner was reviewed on a monthly basis by the management team to ensure that all staff were up to date in mandatory training and residents' needs specific training. Whilst there were some outstanding training requirements these had been previously identified and training dates had been booked. Also the person in charge had initiated new training for staff to commence due to a change in needs of one resident. Training had also taken place for all persons in charge and deputy persons in charge on the Trust in Care processes.

A record of all incidents occurring was maintained in the designated centre and for the majority incidents were being notified to the Office of the Chief Inspector. Improvements were identified in the areas of notifying restrictive practices.

Regulation 14: Persons in charge

The person in charge was appropriately qualified and experienced and had a good understanding of the residents' care needs. The person in charge was also conducting regular audits of the quality and safety of support provided, which ensured that a good level of care was maintained.

Judgment: Compliant

Regulation 15: Staffing

The provider had not ensured that an appropriate number of staff was employed to meet the assessed needs of residents.The additional staffing arrangements were subject to funding and were not yet in place/approved at the time of inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Arrangements were in place for staff supervision and records were maintained of supervision meetings, improvements were required with the frequency of the meetings to ensure they were in line with local policy. Records reviewed indicated that staff were provided with training in areas such as fire safety, safeguarding, de-escalation and intervention and medicines management. It was noted though that some staff were overdue refresher training but dates had been booked for staff to receive such training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had made improvements to the management arrangements to ensure that there were robust governance and management structures in place to oversee the operational management of the service and to provide appropriate oversight of the quality of care provided. Improvements were required to ensure that the centre was resourced sufficiently to ensure the effective delivery of care and support to residents.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had not taken any new referrals for admissions until a review of the admission policy was updated alongside new contracts of care. This review was still undergoing at the time of the inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Overall, notification of incidents were reported to the Authority in an appropriate and timely manner however, the inspector found that two restrictive practices had not been included on the necessary quarterly notification.

Judgment: Substantially compliant

Quality and safety

The inspector found that since the previous inspection a key improvement in care and support of residents had been made in relation to protection and safeguarding. However, quality and safety in the long term in this centre was linked to staffing levels and resourcing of the centre which were found to still require improvement.

Remedial works had been carried out in the centre to repair the roof; and short term works had been completed to improve the grounds and reduce the risk of trips and falls. Whilst quotes for more substantial work had been received these had not yet been approved. Additionally other maintenance and premises issues identified by management such as outside lighting, ramps and painting were awaiting completion at the time of inspection.

It was identified on the previous inspection that professional care planning, delivery and the ongoing development of care plans required improvement. The person in charge and nurse had completed a full audit of all residents personal plans in February 2019 to ensure that the plans were in were in line with resident's needs and were reviewed for effectiveness. This audit included key compliance requirements such as needs assessment, personal plans, risk assessments and contract of care. Whilst a number of gaps and inconsistencies were identified, the analysis completed resulted in a time bound action plan with actions broken down into management, maintenance, accuracy and relevance sections. These actions were due to be completed by March 1st 2019.

The staffing levels were found to negatively impact on the leisure opportunities and activities available to residents. One resident spoke to the inspector and expressed their desire to partake in more outings and this area of improvement was identified by management in a provider review of the care and safety of residents.

Following a notification from the provider in relation to a resident financial safeguarding concern, a request was issued by the office of the chief inspector for further assurances from the provider. An appropriate response from the provider was submitted and on inspection it was found that measures were implemented to prevent re-occurrences and strengthen the arrangements in place to safeguard resident monies. A critical incident learning notice was issued to all staff and a new standard operating procedure was developed. Unannounced checks on finances had also occurred to ensure adherence to the new system. An audit on other safeguarding concerns in the centre had also taken place which led to actions and recommendations in preventing these in the future.

Regulation 13: General welfare and development

There were various activities available to residents on site of the designated centre however, residents did not always have appropriate opportunities to participate in activities in accordance with their interests outside of the centre.

Judgment: Substantially compliant

Regulation 17: Premises

Improvements were identified with some ground works outstanding. The provider had a plan in place to address these issues, however these plans were not time bound or funding approved.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had an individual personal plan in place. A review of the individual plans identified gaps contained within, the person in charge had put in place an action plan to address this. Also the personal plan required to promote participation in meaningful activities through the day which are in accordance with residents wishes, hobbies and age.

Judgment: Substantially compliant

Regulation 8: Protection

Safeguarding plans, measures and systems were all reviewed since the previous inspection. There was evidence that investigations were instigated were necessary. There was an increased safeguarding awareness and review of financial safeguards were in place for residents' finances.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Grangebeg Camphill Community OSV-0003621

Inspection ID: MON-0026403

Date of inspection: 14/02/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing level as per our compliance plan from July 2018 was reviewed through an Operation and Finance review using a comprehensive needs assessment tool. Immediate advertisement of 3 WTEs to commence. CCoI Quality Improvement Plan and operational and finance review and associated centre staff WTEs, has been submitted to the to HSE on the 19th of April 2019. Recruitment of the identified WTEs to be completed by 21/06/2019. Recruitment processes to date: One in February which has secured 1 WTE for the residential service and this staff member will start their employment the first week in May 2019. We have advertised and have interviews to be held on the 29th and 30th April 2019. We continue to engage agency staff 50 – 60 hours per week, our intention is reduce our reliance on agency staff through recruitment of adequately trained employed staffing.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A full audit of staff supervision systems was completed prior to inspection. DPIC is supporting staff teams to address gaps in supervision. Training in supervision practice will be rolled out to all line managers providing staff supervision. This will be via an in-house training Programme developed and available for delivery. Supervisees will receive	

training in function and purpose of supervision is their first session / supervision contract session. Completion 30th September 2019

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Following completion of the operational and financial review that has been submitted to the to HSE on the 19th of April 2019 a new regional structure is to be formulated that will reduce administration within the center. 31st July 2019.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: Resident's Contracts are under review and will be finalized by the 14th June 2019. New admissions policy is currently being drafted to ensure that resident's needs are adequately addressed within the admissions policy. New admissions will only commence on completion of recruitment for adequate staffing levels. 21st June 2019.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Restrictive Practices identified by the inspector on this visit are a door alarm on a fire door and bedroom door to alert staff to resident leaving their room at night. As they have an ABI, they can become disorientated and have left the building and been at risk of an accident or an incident occurring to them. Also, a stair gate in place at night time in case they become disorientated and fall down the stairs. These were not identified as restrictive practices on past inspections. The PIC will create a practice register and return

in quarterly notifications. As will non-medical incidents and accidents for residents which was an omission by the PIC in notifying them in the third and fourth quarter of 2018. By when 30th April. All restrictive practices will be independently reviewed by the clinical lead for Camphill before initiation and on a regular basis thereafter (no less than 6 monthly).

Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: Increase in staffing levels will support residents' opportunities outside the Centre 21st June 2019.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Funding for pathways secured through donations and implemented on a staggered installation basis by 27th of September 2019. The recommended enhancement of external lighting completed 28/2/2019.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: Recommendation of Internal audit Feb 2019 will fully be implemented by 31/05/2019 A revision of the full set of PCP and supporting documents is under review in Camphill and be completed by 30th June 2019. The PIC attends each of the resident's annual reviews and a specific focus is given to personal wishes, goals and preferred social choices in center and within the wider community. Completion 31/05/2019.	

Assessment needs template to be used for all new and existing residents, 30th June 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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	21/06/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	21/06/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is	Not Compliant	Orange	21/06/2019

	appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	21/06/2019
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2019
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	21/06/2019

Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	21/06/2019
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	30/04/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/04/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the	Substantially Compliant	Yellow	30/04/2019

	designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			