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:	Camphill Community Grangemockler
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	13 May 2019
Centre ID:	OSV-0003622
Fieldwork ID:	MON-0026805

About the designated centre

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

Camphill Community Grangemockler consists of four large separate detached houses all within short walking distance to each other. These houses are located in a rural area on the site of a farm and are in close proximity to a small village. The centre provides a residential service for up to twenty-one adults, male and female, with intellectual disabilities, Autism and those with physical and sensory disabilities. In line with the model of care, residents are supported by a mix of paid staff and volunteers. The centre does not accept emergency admissions.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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
13 May 2019	09:50hrs to 18:45hrs	Conor Dennehy	Lead
13 May 2019	09:50hrs to 18:45hrs	Sinead Whitely	Support

Views of people who use the service

The inspectors met ten of the residents who were living in the centre at the time of this inspection. These residents used a mixture of verbal and non-verbal communication. As a result the inspectors engaged with residents in a number of ways. For example, some residents were observed in their environments and in their interactions with staff while four residents spoke with the inspectors.

The residents who spoke with the inspectors indicated that they were happy living in the centre and with their daily activities. Two residents specifically said that they felt safe living in the centre and were satisfied with the support they received from staff. One of these residents referred to living in the centre as being 'like paradise'.

Resident and staff interactions were observed by the inspectors. It was noted that residents appeared relaxed in staff members' presence. Residents and staff were also seen engaging together in a positive, warm and respectful manner. It was also seen that residents appeared comfortable within their living environment.

Capacity and capability

At the time of this inspection the registered provider had improved the governance and level of oversight to ensure that residents were appropriately supported. This was reflected by an overall good level of compliance across the regulations reviewed. It was noted though that such systems were not working effectively throughout 2018.

This designated centre had last been inspected by HIQA in January 2018. In January 2019 HIQA were informed that matters of a potential safeguarding nature, relating to the period September to December 2018, had not been reviewed and investigated in a timely manner. At the time, additional assurances were received from the provider and while HIQA were satisfied that there was not an immediate risk to residents living in this centre at that time, the information provided raised some concerns regarding the safeguarding processes followed and overall management systems that were in place. As a result the primary purpose of this inspection to assess compliance in such areas.

During the current inspection it was observed that potential safeguarding issues, relating to the period January 2018 to August 2018, had not been correctly reviewed or investigated to in a timely manner also. This had been recently identified by the provider and it was noted that appropriate measures were now being taken to investigate these matters. However, in light of these issues and the information

received in January 2019, it was not demonstrated that those responsible for addressing these matters in the first instance did so effectively throughout 2018.

It was also observed that the management systems in place during 2018 were not operating effectively. For example, under the regulations the provider is required to carry out unannounced visits to the designated centre every 6 months to review the quality and safety of care and support that is provided to residents. Such a visit should be reflected in a written report along with an action plan to respond to issues identified. No evidence was provided during this inspection that any such unannounced visit had been carried out by the provider between January 2018 and April 2019.

It was seen though that in the months leading up to this inspection, the level of oversight from the provider had improved with an unannounced visit carried out in April 2019 which focused on the quality and safety of care and support offered. It was also seen that new management personnel had been put in place to oversee the operations of this centre. This included a new regional manager, a new person in charge and a new safeguarding officer. The regional manager had a number of designated centres under their remit so to ensure that they were aware of the operations of the current centre, weekly information was sent to them by the person in charge. Within the designated centre weekly meetings also took place where matters relating to the running of the centre were discussed.

The new person in charge had been appointed to this role in February 2019 and was responsible for this designated centre only. The person in charge was found to be appropriately experienced and skilled to perform the role and was in the process of completing a management qualification at the time of this inspection. Any issues or queries that were raised during the inspection were responded to promptly by the person in charge. Supported in their role by two deputies, the person in charge oversaw the workforce that was in place in the centre. In line with the provider's model of care, the workforce consisted of paid staff members and volunteers.

Based on the overall findings of this inspection, appropriate staffing arrangements, as supplemented by the volunteers, were in place to support residents. Nursing input was also available within the centre. To ensure both volunteers and staff were equipped with the necessary knowledge to support residents, training in relevant areas such as fire safety and safeguarding was provided. Staff and volunteers spoken with by inspectors demonstrated a good knowledge of residents' needs and the supports they required while arrangements for supervision were also in place.

Staff files were maintained in the designated centre which included all of the required information such as proof of identification, written references and evidence of Garda Síochána (police) vetting. Maintaining such files is important to provide assurances that robust recruitment practices are followed by a provider. It was noted though that files for agency staff were not present in the centre on the day of inspection. This was queried with the person in charge who obtained evidence of Garda vetting for all agency staff by the end of the inspection and made arrangements to obtain complete files for them. Evidence of Garda vetting was in place for volunteers although it was noted that their roles and responsibilities were

not set out in writing as required under the regulations.

Regulation 14: Persons in charge

The current person in charge was appointed to this role in February 2019 and was responsible for this designated centre only. Based on the overall findings of the current inspection and previously submitted information, the person in charge was suitably skilled, experienced and qualified to perform this role.

Judgment: Compliant

Regulation 15: Staffing

Appropriate staffing arrangements, as supported by the provision of volunteers, was in place to provide support to residents. Nursing input was available while a continuity of staff was also in place. A sample of staff files were reviewed which contained all of the required information such as evidence of Garda vetting and written references. It was noted though that staff files for agency staff were not present in the centre on the day of inspection although evidence of Garda vetting was seen for such staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Arrangements were in place for staff to receive supervision while training was provided in areas such as fire safety and medicines. Adequate arrangements were also made for staff to receive refresher training when required.

Judgment: Compliant

Regulation 23: Governance and management

No evidence was provided during this inspection that any 6 month unannounced visit to the centre had been carried out between January 2018 and April 2019. An annual review of the designated centre had been carried out in December 2018 but did not clearly set out the outcome of consultation with residents and their representatives. It was not demonstrated that those responsible for overseeing

issues of safeguarding matters were effectively overseen by the provider throughout 2018.

Judgment: Not compliant

Regulation 30: Volunteers

Evidence of Garda vetting was in place in sample of volunteer files reviewed while arrangements were also in place for volunteers to be supervised. It was noted though the roles and responsibilities of volunteers were not set out in writing.

Judgment: Substantially compliant

Quality and safety

The inspectors were satisfied that residents were appropriately supported and no immediate safeguarding concerns were identified during this inspection. It was noted though that some potential safeguarding concerns throughout 2018 had not been reviewed and investigated in a timely manner.

Inspectors reviewed the processes in use for responding to any potential safeguarding concerns. It was seen that, at the time of this inspection, any such matters were being reviewed and investigated in a timely manner with specific safeguarding plans to prevent against any potential harm being put in place where necessary. It was noted though that a number of potential safeguarding concerns from 2018 had not managed in proper or timely manner. This had been identified by the provider in April 2019 and it was seen that appropriate steps were being taken at the time of this inspection to review and investigate these matters.

Where deemed necessary, safeguarding plans were seen to be place. Staff members and volunteers spoken with during this inspection were also aware of any safeguarding issues present in the centre and the measures to be taken to prevent any possible harm. Residents also had detailed intimate care plans in place to guide practice in this area. Training records reviewed indicated that all staff had been provided with relevant safeguarding training. It was reported by staff members spoken with that there were no barriers to reporting any concerns. It was also observed that residents appeared comfortable in the presence of staff members with two residents clearly indicating that they felt safe living in the centre.

Throughout the inspection residents were seen to be treated in a respectful manner by staff and volunteers. It was observed that active efforts were made to ensure residents' privacy. For example, one staff member was seen to knock on a resident's bedroom and ask for permission before entering the bedroom. Only when the

residents granted permission did the staff member enter. It was also noted that residents were supported to exercise their right to vote and were consulted in relation to the running of the centre. This was achieved through regular meetings with the residents in each house of the centre.

To ensure residents were appropriately supported, their needs were set out in their individual personal plans. Such plans are required by the regulations and are important is outlining the needs of residents along with the supports necessary to provide for these. The inspectors read a sample residents' personal plans and noted that they had been informed by relevant assessment, had been subject to annual review and had the involvement of residents and their representatives. The inspector found that these plans contained clear guidance on how to support residents, the contents of which were known to staff and volunteers present.

Included within residents' personal plans were specific positive behaviour support plans. These are intended to provide guidance on how to support residents to engage in positive behaviour. Inspectors reviewed a sample of these and found that they provided clear and detailed guidance in such areas. These plans were also noted to have been recently reviewed. Staff members spoken with during inspection demonstrated a good knowledge of how to support residents with their behaviour. This provided assurance that there was a positive approach to the management of behaviour that was tailored to meet the needs of residents living in the centre. It was also noted that systems were in place for the review of restrictive practices in use.

During this inspection it was also seen that residents were supported to enjoy the best possible health. To ensure this, residents had annual health checklists carried out and were facilitated to access a range of allied health professionals such general practitioners, opticians, dentists, chiropodists and speech and language therapists. Particular interventions such as vaccines and specific assessments were also facilitated along with support for residents in managing their medicines. It was noted though that clear guidance for a PRN medicine (a medicine only taken as the need arises) was not in place for one resident. Such guidance is important to ensure that such medicine is taken as prescribed.

Regulation 26: Risk management procedures

Systems were in place for the review of any risks in the centre. Inspectors reviewed a sample of documentation in place related to risk management and noted that identified risks were reflected in risk assessments which had been recently reviewed. Such risk assessments outlined the necessary controls to reduce the potential impact of the identified risks.

Judgment: Compliant

Regulation 28: Fire precautions

This regulation was not reviewed in full but during the inspection it was observed that two fire doors, intended to prevent the spread of fire and smoke, were held open preventing them from functioning as intended. It was also noted that a review of the designated centre has been carried out by a suitably competent person who made some recommendations regarding fire containment measures.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate arrangements were observed to be in use regarding medicines in areas such as documentation and storage. It was also seen that residents were being assessed and supported to self administer their own medicines. It was seen though that the medicines documentation in place did not clearly set out the circumstances where a particular PRN medicine was to be given.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had individual personal plans in place which set out their needs. Such plans had been informed by relevant assessments, were developed with the input of residents or their families and were subject ot annual review. Based on the overall findings of this inspection, arrangements were in place to meet the assessed needs of residents.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of residents were outlined in their personal plans. Residents were supported to access a range of allied health professionals such as general practitioners, dentists and chiropodists. Residents were also supported to undergo particular healthcare interventions such as vaccines and assessments as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had behaviour support plans in place and staff members spoken with on inspection demonstrated a good knowledge of these. Relevant training in de-escalation was also provided. Systems were in place for the review of restrictive practices in use.

Judgment: Compliant

Regulation 8: Protection

A number of potential safeguarding concerns from 2018 had not been investigated or managed in proper or timely manner at the time they arose.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were seen to be treated in manner which respected their rights. Residents were consulted in relation to the running of the designated centre through regular house meetings while residents were also supported to vote.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community Grangemockler OSV-0003622

Inspection ID: MON-0026805

Date of inspection: 13/05/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All schedule 2 documents have been requested and agreed to be in hand with the service provider by the 28th June 2019. The Provider has undertaken to ensure that all agency staff who are rostered to work in the service have all relevant schedule 2 documents. Agency coordiantor and service now have an agreement in place that no new agency staff will be allowed to work unless the relevant schedule 2 documents are on individual agency staff files in the serrvice. All staff employed within the community have completed relevant trainings which include, HSE Safeguarding Vulnerable Adults, Childrens First, fire training and where relevant Safe adminastration of Medication and Manual Handling. Continuity of care and support is provided to all residents by staff members. This is managed by a weekly roster which is in place and clearly illustrates who is on duty during the day and night in each resedential centre at a given time	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A clearly defined management structure is in place within the designated centre. All roles are specified with clear lines of accountability and responsibilities in place which covers all areas of service provision within the designated centre. Weekly handovers are provided to the PIC for each of the four houses. The PIC also submits a weekly handover to the Regional Manager, which allows for oversight at a national level of any	

issues which may arise from week to week. KPI's are also provided to the organisation monthly which also facilitates oversight and governance on a national level. The PIC also attends a weekly welfare meeting which discusses all aspects of residents care and support, this meeting is also attended by the DPIC and the Clinical lead for the designated Centre. The PIC and DPIC rotate attendance as relevant at weekly house meetings to provide oversight into each of the four resedential centres. The Regional Manager is onsite monthly. There is anew National Clinical Lead in place that provides support for Personal Care Plans, Behavious of Concern, Medication Management and Restrictive Practice along with a Regional Behavioural Support Specialist. There is a weekly dial in for PIC and DO that offers support, guidance and updates. All staff are in receipt of Supervision in line with Camphill Policy. There is a National Quality & Safety Lead who oversees Risk Management Training, Complaints, Accidents/Incidents, Audits, Health & Safety and Quality Improvement Initiatives
An internal Unannounced Inspection took place on April 18th with another one scheduled for later in the year.
An annual review in December 2018 of the quality and safety of care and support in the designated centre has taken place on schedule and has been actioned and timelined. The next annual review will clearly outine feedback from consultation with residents and family members

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
All Volunteers now have their roles and responsibilities set out in writing. All volunteers also receive supervision on a weekly basis. The service provider also holds copies of vetting disclosures in accordance with the National Vetting Bureau Children and Vulnerable Persons Act 2012. Where Necessary international police checks are also carried out and retained on file prior to any volunteer's engagement with the service.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire doors have been fitted with Fire Door Retainers to facilitate residents wishes of having the fire doors open and allowing for automatic closure in the event of a fire alarm sounding. A review of all doors within the designated centre has also carried out by a competent person to assess their function and compliance with fire safety protocols.

A competent person is also in the process of being commissioned to carry out necessary inspection works for fire containment measures. These inspection works will be

approved by the end of Q2 2019. The importance of preventing fire doors from closing will be reiterated at all house meetings in the Designated Centre

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All PRN protocols have been reviewed and are in place 14/06/19 for all PRN medications used for resident's in the community by the community nurse.
There are robust systems in place with quarterly audits of medication management by the community nurse for all the houses. All areas of medication management are informed by HIQA Medication Management guidance document 2015, the Health Act 2007, Guidance for health and social care providers Principles of good practice in medication reconciliation 2014, Assisted Decision-making (capacity) Act 2016. The consent policy 2014, Guidance to nurses and midwives on Medication Management NMBI 2007. All residents have regular medication reviews by their chosen GP and have a pharmacist available to them that is acceptable to them. There is a risk assessment in place for all residents for self-administration of medication and they are encouraged to be involved according to their wishes and preferences in all aspects of their medication management. All medications are kept securely in a locked cupboard in each of the houses and for those who wish to self -medicate there is a locked cupboard provided for them in their room. Camphill Grangemocker adheres to best practice guidelines in relation to the ordering, receipt, prescribing, storage and disposal and administration of medicines as set out in HIQA Medicines Management Guidance document. All medication incidents are reviewed by the community nurse and learning documented, discussed and actions implemented at weekly community meetings. Incidents are reviewed weekly at national level by the National Clinical Lead.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A new Designated officer has been appointed within the service location. Part of their role was to audit and investigate any areas of concern within the service. The time period of 2018 is included in this audit. There has also been significant change at both a regional and national level for Camphill Communities of Ireland. New Regional Safeguarding Leads are in place and are providing support to individual communities with their remit. Camphill Grangemockler and the Regional Safeguarding Lead have worked in collaboration to ensure all areas of concern are being appropriately addressed. All

safeguarding concerns are addressed with the oversight and input from these new Regional Safeguarding Leads. CCoI have also appointed a new Principal Social Worker and is directing both the Regional Safeguarding Leads and also the communities at a local level. The new Principal Social Worker is also in the final draft stages of development of a national Safeguarding Improvement Plan, which will be shared with all communities.
Significant improvements have been made in terms of review of each resident safeguarding file. This process is being overseen by the Principle Social Worker (Safeguarding). A revised Safeguarding Tracker will be introduced in July 2019. This will automatically feed into the national safeguarding oversight system in Camphill.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	28/06/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/08/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more	Not Compliant	Orange	31/10/2019

	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.			
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	28/06/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	17/06/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt,	Substantially Compliant	Yellow	18/06/2019

	prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 30(a)	The person in charge shall ensure that volunteers with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	17/06/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	17/06/2019