

**Health Information and Quality Authority
Regulation Directorate**

**Compliance Monitoring Inspection report
Designated Centres under Health Act 2007,
as amended**



Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003607
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Provider Nominee:	Adrienne Smith
Lead inspector:	Noelene Dowling
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	1

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:

- Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
- Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:

- to monitor compliance with regulations and standards
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
- arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to inform a registration decision. This monitoring inspection was un-announced and took place over 3 day(s).

The inspection took place over the following dates and times

From:	To:
28 June 2016 02:00	28 June 2016 07:30
29 June 2016 08:30	29 June 2016 17:00
20 July 2016 17:30	20 July 2016 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 04: Admissions and Contract for the Provision of Services
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 09: Notification of Incidents
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

Background to the inspection

This was the third inspection of this centre. It was a follow up inspection undertaken to ascertain the provider's actions following on from a registration inspection of January 2016. The findings of that inspection included three major non compliances in safeguarding, health and safety and governance. There were significant concerns regarding the use of one building which was found to be both unsafe and unsuitable for one resident who was living there. As a result of that a specialist review was undertaken by The Health Information and Quality Authority (HIQA) fire safety inspector on 26 January 2016 and a detailed action plan outlining the actions to be taken was issued to the provider.

In April 2016 as a result of concerns regarding overall safeguarding systems and responses within the organization the provider was requested to attend a meeting with HIQA. Following this meeting a warning letter was issued and the provider was

requested to submit a plan to improve safeguarding systems within the organisation. This was duly received.

Description of the service

The configuration of the service has altered since the previous inspection. A revised application was received from the provider to include one additional unit to the application to replace the unsuitable building. This did not alter the number of residents to be accommodated. The current application is for 12 residents. One unit which had been included in the original application was being withdrawn by the provider as it does not meet the requirements for a designated centre.

Service is provided to 12 residents in two residential units which accommodate four and three residents and five separate apartments which accommodate one resident in each.

Co-workers and volunteers also live in the units with the residents. The unsuitable premises is to be replaced by a small cottage on the grounds which was in the process of being renovated when inspectors visited on day one and two of this inspection. On day three of this inspection, the lead inspector revisited the centre to review the cottage as HIQA had been advised that renovations works on the cottage were complete. The provider intended to close the unsuitable part of the premises once this cottage was registered.

The centre is located in the small rural town with easy access to all services and amenities. There is a farm/garden in one area which is used by residents.

The statement of purpose indicates that the care will be provided to residents with some physical dependency needs, low to moderate intellectual disability challenging behaviour and persons on the autism spectrum.

To this end the care practices are congruent with the statement of purpose.

How we gathered our evidence:

The inspection was unannounced. Inspectors met with four residents and staff, observed practices and observed a staff meeting in relation to one resident's placement. Inspectors also met with the nominee of the provider who was carrying out the required unannounced 6 monthly visit to the centre on the same day. Inspectors reviewed documentation including policies and procedures, personnel files, health and safety documentation, residents' records and personal plans, accident and incident records.

Residents with whom the inspectors spoke were very complimentary regarding the care they received and the support the staff provided to them.

Overall judgement of the findings

There were a total of 33 actions required from the previous inspection. Of this number 23 had been satisfactorily resolved and progress had been made on the remainder.

The provider had made significant progress in making safe the unsuitable premises in the provision of suitable fire safety systems and fire doors as an interim measure. The additional premises to replace this unit was inspected on 20 July 2016 and found to be suitable for purpose with all of necessary fire safety documentation available.

Issues which still required attention were in relation to safeguarding, governance and adherence to recommendations of allied health professionals and provision of information to HIQA.

Overall, inspectors noted improvements in many areas which resulted in positive outcomes for residents.

Good practice was identified in areas such

- Social care (outcome 5) which ensured residents had meaningful lives
- Healthcare (outcome 10)
- Medicines management (outcome 12)
- There were sufficient staff to meet the needs of the residents (outcome 17)

However, inspectors were not satisfied that the governance arrangements were sufficient to ensure care was effectively delivered and safeguarding systems were robust. This resulted in:

- Some risks not being identified or responded to in health and safety due to limited risk management procedures (outcome 7)
- Poor safeguarding measures and systems which could expose residents to risks (outcome 8)
- Staff training in specific issues pertinent to the residents (outcome 17)

The detail of these are outlined in the report.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

In general residents' rights were protected and promoted while residents were actively consulted in the running of the centre.

The specific actions from the previous inspection had been satisfactorily resolved. An external advocate had been sourced for one resident who required this and had attended the annual review. The person in charge outlined the process for ensuring this support continued for the benefit of the resident. A review of the complaints records indicated five complaints had been made since the previous inspection. These had been addressed and resolved. The process had been altered so that the person in charge was the person nominated to review and oversee the process and outcomes of the complaints to ensure they were fair and adhered to.

The action in relation to the privacy and dignity of one resident was in the process of being addressed with the final completion of more suitable living accommodation for the person. In addition, the inappropriate audio monitors had been removed from the residents' bedrooms.

It was evident that residents were facilitated to exercise choice and control in their daily lives. Residents told inspectors of engaging in various activities such as baking, gardening and drama. Resident meetings were held on a weekly basis. Inspectors reviewed minutes of these meetings and noted that they were forums for discussion of general activities, local events of interest and staff changes. Other forums such as individual support meetings and individual time with key workers were used to elicit choices and concerns from the residents.

Policies were in place for managing residents' personal property and finances. Inspectors reviewed property lists which were kept up to date. Residents were encouraged and supported to remain in control of their own finances where this was deemed appropriate and transparent records of spending on behalf of residents were maintained. There was a policy on the use of resident's monies and systems for oversight of decisions were outlined by the person in charge.

Throughout the inspection staff members were seen engaging with residents in a respectful and caring manner. It was apparent that the privacy of residents was respected.

Judgment:
Compliant

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There was a suitable policy on the procedure for admission which was in accordance with the regulations and which outlined the assessment and decision making process. There was evidence that that consideration was given to the compatibility and safety of residents when such decisions were made.

A contract for the provision of care and the services to be provided was issued to the resident or their representative for signing. However, it was noted that this contract did not specify the fees to be charged for the services. The provider was aware of this and was in the process of making the required changes. Again, however, the contract was in some instances not signed by a representative of a resident where this would be required due to the resident's dependency levels.

There was detailed transfer information available should a resident require admission to acute care services.

Judgment:
Substantially Compliant

Outcome 05: Social Care Needs

Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

There were two actions required following the previous report which required referrals for re-assessment of residents' psychological health and the inclusion of multidisciplinary intervention in the annual reviews.

These had been addressed. From a review of a sample of four residents' personal plans and records annual reviews had been held and were informed by the interventions of the multidisciplinary supports involved with the residents. Where residents could not or choose not to attend the formal reviews, separate meetings were held to ensure they were included and participated in the process. Relatives or external representatives also attended the annual reviews.

As required, referrals to mental health and psychological specialists had been made and appointments had either taken place or were scheduled to take place. A speech and language therapist had been sourced for a resident and communication passport devised following this.

The personal plans available were comprehensive in that they informed all aspects of the resident's life and any changes were clearly identified in the plans and reviews.

There were assessments undertaken for daily living skills, behaviour supports, health care needs and moving and transporting requirements where necessary.

In most instances the interventions of allied specialists including physiotherapists, occupational therapists, opticians, dentitions and general practitioners (GPs) were seen to inform the personal plans and, for example, staff undertook exercises with a resident in accordance with the direction of a therapist. However some specific recommendations made to support a resident had not been implemented. One was the purchasing of an electric toothbrush to avoid a situation of anxiety for the resident ,sourcing a specialist sensory assessment and the use of objects of reference and communication cards. There was no reasonable rational why these matters had not been addressed.

Residents' social care needs and aspirations remained very well supported and encouraged. All were involved in a range of meaningful activities social events and occupation. They went on regular holidays with relatives or with staff, went horse riding, swimming, took part in the local community events with one resident holding a plant sale during the inspection. The one to one staffing levels supported these initiatives where necessary. Otherwise the residents' independence was encouraged.

One resident informed inspectors of their work in a preparation for employment training course. Some took part in local art exhibitions and did computer skills. They participated in the farm work, worked in the bike shop, did weaving and craft making. Inspectors saw that the residents participated in the daily life of the houses, for example they helped with laundry, cooking and undertook general housekeeping or gardening chores to promote their independence, a sense of participation and inclusion in the life of the centre. One resident was the unofficial health and safety officer for the house.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The designated centre consists of seven units comprised of one stand alone residential house, one residential unit located above a community centre and administration offices, four supported apartments and one premises which dated back to the 19th Century. One of the units originally listed as part of the application has been removed by the provider as not meeting the criteria of a designated centre and inspectors found that this provided for a better service to the resident involved.

Some interim improvements had been made to the 19th century unit in that the resident's bedroom had been relocated to the ground floor and a more suitable bathroom was available. The condition of this latter unit remained unsuitable to meet the needs of the remaining resident who lived there. On the third day of inspection, it was noted that renovation of the garden cottage had been completed to a high standard to facilitate the replacement of the older building.

This replacement unit is a small two bedroom cottage on the grounds of the regional unit. This was visited on completion on 20 July 2016 and found to be finished to a high standard and very comfortable. It contains a suitable kitchen and living room , a bedroom for the resident and bedroom for staff. A suitably adapted shower room was also provided. There was an alarm systems in place. It has large garden areas outside.

Since the previous inspection some remedial works had been carried out throughout the units to improve fire safety systems.

In general, the design and layout of the units was suitable to meet the needs of residents. They units were of sound construction, clean, spacious and decorated in a homely, warm manner. Residents spoken with indicated that they liked living in these units and had significant choice in the décor and how they furnished and maintained their rooms. They had significant amounts of personal possessions which gave these units a very homely feel.

In the shared units there was ample space for privacy or time alone apart from the resident's individual bedrooms and the living areas were comfortable and spacious. Outside grounds and gardens were available. Toilets and showers were suitable for use by the current residents and a ceiling hoist had been installed for one resident.

There was evidence of servicing of this and all other equipment necessary for the residents.

Inspectors found these units to be suitable in terms of accessibility. Suitable kitchen, laundry facilities were in place. Other issues identified such as cleaning and plumbing works had been addressed.

With the removal of the 19th century building and the inclusion of the refurbished unit the premises will be suitable for purpose.

Judgment:
Substantially Compliant

Outcome 07: Health and Safety and Risk Management

The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were nine actions required following the previous inspection and most had been partially resolved. The risk management policy had been revised as required to include a framework for the management of accidents, incidents, self harm and absconding.

The system for learning and review of untoward events was included in the policy. A revised template/system for monitoring and categorising incidents had been implemented. This was however in the early stages and was not yet fully embedding practices. Some improvements were still required in the systems for assessment of risk and implementation of learning from incidents.

This is demonstrated by the following:

Eight medication errors had taken place since February 2016. The information had been collated on the revised templates for collating such data. However, the information had not had not been sufficiently analysed to identify casual factors and the actions taken were not sufficient to prevent re-occurrences. Inspectors also noted that there were delays before the incidents were reviewed although they were reported promptly. In two of the incidents lapses of up to 10 days were noted before a review took place.

The systems for identifying and categorising risk, taking potential impact into account, were not robust. For example, in one unit a landing window opened directly onto a flat roof. This could easily be accessed by residents. The person in charge stated that this was not deemed a risk to the current residents. However, the potential impact and consequence of a fall from the roof had not been considered. This matter could be addressed without undue adverse impact on the residents.

The lack of appropriate risk assessment for the continued use of lighted candles had not been addressed.

While an assessment for necessity for the use of a bedrail had been undertaken there was no system for monitoring the safety of the bedrail itself and monitoring the resident overnight while it was in use.

Individual risk assessment were undertaken for residents for issues such as falls or seizures or unauthorised absences. However, the management plans for a resident assessed as being at risk of an absence was not detailed or timely enough to mitigate the risk.

Inspectors were informed that following the previous inspection, a door key had been provided for a resident to ensure they could independently return to the unit at night without leaving the remaining residents in the house at risk from unauthorised persons.

There were significant fire safety issues identified at the previous inspection including the provision of suitable alarms, emergency lighting, means of escape and making safe sections of the 19th century building.

Inspectors found that the provider had undertaken all of the required works in relation to these. Evidence of the commissioning of a suitable fire alarm, emergency lighting and

escape routes were forwarded to HIQA. Inspectors also observed these in place as well as suitable fire doors in the required locations. Sleeping accommodation for the resident who currently resides in the building was relocated to the ground floor as agreed for safety reasons.

The remaining units had required some remedial works in relation to fire safety and these had been addressed. This included moving another resident to a more suitable bedroom to ensure safe exit in the event of a fire, installation of further fire doors and smoke vents. The unsuitable fire exit which required the use of an unsecured ladder from a roof had been removed. The alarm system in another unit was upgraded.

Fire training had taken place for staff and staff spoken with could outline the procedures in the event of fire. Staff were also trained in the use of the evacuation chair required for a resident. Regular fire drills were recorded at various different times. There was evidence that fire alarms, emergency lighting and extinguishers were serviced annually and quarterly as required. There was documentary evidence of regular checks of the alarms and exits.

All fire safety documentation including commission certification for the fire alarms and emergency lighting and fire fighting equipment was forwarded following the inspection.

The inspector visited the newly renovated garden cottage unit on the 20 July 2016 and observed all systems were in place with suitable fire evacuation plans, emergency exits and procedures in place.

An emergency plan had been revised to include procedures for loss of heating. There was a current and signed health and safety statement available. A health and safety audit had taken place in 2015.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

There were two actions required from the previous inspection. These were the use of restrictive practices including inappropriate listening devices, the safe use of bed rails and appropriate safeguarding actions when potentially abusive incidents occurred. The inspectors saw that the listening devices were no longer in use and there were improvements in the assessment and usage of bed rails. Inspectors were informed that no other restrictive practices were utilised.

Inspectors were not satisfied however that the safeguarding systems were effective in practice, that there was sufficient understanding within the centre or the organisation of procedures and good practices or that they were sufficiently monitored and overseen.

An issue of particular concern which did not impact directly on residents but indicated there were grounds for concern had been notified to HIQA prior to the inspection.

Following this there was no further information provided until this was requested by the inspector. The information which was eventually forwarded indicated that while the initial actions of the provider were satisfactory the follow on actions were not in accordance with good safeguarding practices and adherence to responsibilities. The direction and oversight of practices at local level was not apparent in safeguarding. This is also actioned under Outcome 14. The provider was requested to submit a separate report on this matter to HIQA following the inspection and agreed to do so.

Training had been provided to the person in charge and the designated officers in implementing the HSE national policy on the protection of vulnerable adults. Staff had also received training with a further schedule planned. Staff were able to inform the inspectors of the reporting systems and the dynamics of abuse. The person in charge informed inspectors that the revised centre policy was in draft form and had not been issued to the centre. However, the provider stated that the policy was in fact available to the centre.

From a review of the records available and notifications forwarded to the Authority inspectors saw improvements in how incidents of concern were responded to at the time and appropriate interventions were put in place according to the nature of the incident. Screening was undertaken and reports were made to the organisations case management team but the evidence of response, closure, outcome or review of the safeguarding plans was not evident at time of the inspection.

There were a number of young volunteers (under 18 yrs) present at the time of the inspection. There were strategies in place to support and provide supervision to these young people. A senior co/worker was assigned to mentor them and there were agreed arrangements for their accommodation and activities and supervision. The inspector spoke with the senior co-worker and found that she was very familiar with her responsibilities in relation to these young people. There were no other children living in the centre at the of this inspection. Inspectors were informed by the person in charge that the practice of having young volunteers would be discontinued. The provider confirmed this also following the inspection.

While there was a policy available on the protection of children and reporting systems neither the designed officer nor staff had training in this matter. The inspector acknowledges that this training had not been available via the HSE for some time and is now being recommenced. The provider stated that staff will be required to attend this training.

The provider had submitted a safeguarding action plan to HIQA in April 2016 following a request to do so. Some of the actions had been commenced including workshops and training for key staff and the sharing of learning from incidents across the different agencies. The implementation of a national monitoring system for responses and compliance with safeguarding requirements was not yet completed. A more significant deficit was the appointment of a fulltime national safeguarding officer. While the timeframe for this had not yet expired the findings indicate this is an urgent requirement.

There was a policy on the management of challenging behaviours which was not satisfactory to guide practice although the inspector saw that behaviour support plans were in place and detailed. Behaviour that challenges was not a significant feature of the service. Where p.r.n. (administered as required) medication was prescribed there was a suitable protocol in place. Inspectors were satisfied that this was not used inappropriately.

Specialist support had been sourced for residents who required this.

The guidelines available for the use of restrictive practices were detailed and in accordance with national guidelines.

There was a policy on the provision of intimate care and support to residents. Details of these were available in the personal plans seen by inspectors. However, the issue of gender preferences and choice had not been considered in one instance. Inspectors were informed that the provider was not acting as agent or guardian for any residents at the time of this inspection.

Judgment:
Non Compliant - Major

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that the person in charge had complied with the responsibility to forward the required notifications to the Chief Inspector but the required follow up information was not forwarded or detailed sufficiently. This is actioned under outcome 14 Governance and Management.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The provider was compliant with this regulation. Residents' overall healthcare needs, including nutritional needs, were met and residents had access to appropriate medical and allied healthcare services. Resident's healthcare needs were reviewed at a minimum annually and as required. There was good access to local general practitioner (GP) services. Annual reviews of resident's health were undertaken and from a review of daily records, inspectors found that there was a prompt response by staff to changes in resident's health.

Where a specific care plan for healthcare needs was required it was available, detailed and staff were familiar with the plans. In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists, dentists and chiropodists. Records of referrals and reports of these interventions were maintained in residents' files. A protocol was in place for the management of epilepsy and the use of emergency medicines. However, this was not consistently known by all staff and the number of staff who were trained to administer the medicine was not sufficient. As there was no negative outcome for the residents this is actioned under outcome 17 workforce.

Inspectors also saw evidence in documentation that residents and their representatives were consulted about and involved in the meeting of their own healthcare and medical needs.

As observed by inspectors and confirmed by the residents the food was nutritious, fresh, choices were accommodated and the mealtimes were social and inclusive occasions with staff and residents sharing all meals together. Where specific dietary needs or supports

with eating and dining were identified by dieticians these were seen to be adhered to. Adapted crockery and utensils were available as needed to encourage independence.

Inspectors saw that residents received support at times of illness and increased dependency. In response to changing needs additional staffing on a one-to-one basis was made available. Equipment such as pressure relieving mattresses and cushions and specialist chairs were sourced. Inspectors noted that the healthcare plan for residents with higher physical dependencies were especially detailed and their health carefully monitored.

A policy on end of life care was in place and inspectors saw that discussions in regard to decision making and care directives were taking place where this was relevant. No residents required such care at the time of this inspection. Inspectors were informed that despite the non medical model of care, every effort would be made including access to nursing support to ensure residents could remain in their home if that was their wish.

Judgment:
Compliant

Outcome 12. Medication Management

Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
No actions were required from the previous inspection.

Findings:
The provider was compliant with this regulation. There was a centre-specific medicines policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines. Any medicine to be administered in an altered format was correctly prescribed.

There was evidence of assessment of capacity for resident who self-medicines in place. There was a system for reconciliation of medicines taken by residents who self medicated.

Most medicines were dispensed in blister packs. There was systems for the identification of medicines on each of the medicines dispensing blister packs.

Staff/co-workers demonstrated an understanding of medicines management and adherence to guidelines and regulatory requirements. Residents' medicines was stored and secured in a locked cupboard in each premises and there was a robust key holding procedure. Inspectors saw and staff/co-workers confirmed that medicines requiring

refrigeration or additional controls were not in use at the time of inspection.

Staff outlined the manner in which medicines which are out of date or dispensed to a resident but are no longer needed were stored in a secure manner, segregated from other medicinal products and returned to the pharmacy for disposal.

Training had been provided to staff/co-workers on medicines management. However, some additional training was required in the use of emergency rescue medication and this is addressed under outcome 17 Staffing. A number of medicine audits on individual residents had taken place. These primarily dealt with administration practices and while errors were promptly noted the process of addressing the contributing factors required improvement. This is actioned under outcome 7 Health and Safety.

Judgment:

Compliant

Outcome 13: Statement of Purpose

There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

The statement of purpose had been forwarded to the Authority as part of the application for registration and the inclusion the new unit. This required a significant number of changes and the person in charge agreed to forward this following the inspection. Admissions to the centre and care practices as seen were congruent with the statement of purpose.

Judgment:

Compliant

Outcome 14: Governance and Management

The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:

Inspectors found that there were improvements in the reporting arrangements, with roles and structures evident and staff were familiar with the functions and roles of the local management team. However, there were still deficits in the implementation of line management reporting and responsibilities.

While there were regular and informal reporting and communication arrangements for the person in charge there was no line management supervisory arrangements to ensure professional responsibilities were carried out and that changes made at organizational level are being implemented at local level.

This is evidenced by the lack of direction and satisfactory action taken in the management of the safeguarding matter outlined under outcome 8, in adherence to the requirement to provide information to HIQA,, in follow through on multidisciplinary interventions for the residents and in the systems for review of accidents and incidents as outlined under outcome 7.

The additional management structure at regional level, defined in the providers national safeguarding plan , as submitted to HIQA, had not as yet been implemented. HIQA acknowledges that a recruitment process was underway and the provider was fully aware that the current arrangements are not sufficient to ensure the safe and effective delivery of care.

The provider nominee was undertaking the unannounced inspection on day one of this inspection which was also unannounced. The report was made available following the inspection and this demonstrated that the process was focused on resident welfare and safety. The provider requested some immediate actions of the local management team in relation to safeguarding processes following this and also issued an action plan to the person in charge for any improvements necessary.

The annual report was not yet available but was in the process of being compiled.

A survey of residents had been undertaken and the inspector reviewed the findings. Overall the outcome was positive and any issues raised were in the process of being addressed. Inspectors were informed that a national survey of the views of relatives or representatives had been commissioned but not yet completed.

An update on the provider's safeguarding action plan had been forwarded to HIQA immediately following the inspection. This did indicate progress being made and also that significant findings from inspection of other centres within the organization were considered.

In discussion with inspectors the provider nominee demonstrated awareness of these factors and of her own responsibilities.

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

The action(s) required from the previous inspection were satisfactorily implemented.

Findings:

The two actions required from the previous inspection had been addressed or were satisfactorily progressed. While staff had received updated mandatory training in manual handling, fire safety, challenging behaviours and adult safeguarding training four of the staff had not received updated medication management training. Staff spoken with knowledgeable on fire safety and safeguarding.

No changes to staff ratios are required for the new unit as the residents own consistent staff will be maintained.

The supervision arrangements for staff had been significantly improved. The responsibilities for supervision had been allocated between the local management team. The records reviewed by the inspectors were detailed and demonstrated an improved focus on residents' care needs, how to address them and training and development for staff. The supportive reflective supervision continued in addition to this.

No medical staff were employed and given the residents' profiles the current arrangements including the numbers of staff and general skill mix available were satisfactory. However, some improvements were necessary to ensure staff were familiar with residents' healthcare needs especially in cases where residents had specific conditions which required on-going monitoring. As highlighted in outcome 12 Medication some staff members required training in the administration of emergency rescue medication in relation to residents who were at risk of seizure.

The workforce in the centre was a combination of short term volunteers, house coordinators/ long term volunteers and paid members of staff in accordance with its function and model of care. A number of residents were provided with one to one staff to support them which could be seen to be of significant benefit to them in their daily lives.

Inspectors reviewed a sample of staff and volunteer files and found that all the required information such as evidence of Garda Síochána vetting was present.

Co-worker and volunteers resided in the designated centre with residents. This served to foster a homely environment and throughout inspection warm, respectful interactions were seen between residents, staff and volunteers. Staff were also found to be very knowledgeable on the needs and the aspirations of the residents.

All long-term co-workers/staff had a range of suitable and diverse qualifications and the employees were social care workers. New staff were briefed in fire safety procedures and there was a detailed induction programme which included supernumerary time for staff. Staff confirmed this to the inspectors.

Judgment:

Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Noelene Dowling
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Action Plan

Provider's response to inspection report¹

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003607
Date of Inspection:	28 June 2016
Date of response:	03 August 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The contract was in some instances not signed by a representative of the resident where this would be appropriate and did not stipulate the fees to be charged for services.

¹ The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:

Under Regulation 24 (3) you are required to: On admission agree in writing with each resident, or their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.

Please state the actions you have taken or are planning to take:

Contract including list of charges to be signed by resident and representative of resident by 16/8/2016.

Meeting with residents re charges will happen on 8/8/16. An appendix to all contracts will be added listing charges to residents and distributed to them and their representatives by 11/8/2016.

Proposed Timescale: 16/08/2016

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Recommendation made following assessment by allied services were not consistently implemented.

2. Action Required:

Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:

All relevant staff are reminded that assessments by allied services need to be re assessed and followed ups need to happen consistently to meet the needs of each resident. By 25/7/2016.

The PiC is reviewing the interlinking between summary of events, the (annual or as required) assessment of need, the Circle and Annual Review meetings, the personal plan, to ensure better flow of information, preparation for annual review and follow up on actions. By 5/8/2016

Circle meetings (team meetings with or without resident) will be reviewed by 29/7/2016 and new procedure and template will be in use from 5/8/2016.

Annual reviews will be reviewed before 5/8/2016 and new procedure and template will be in use from 12/8/16.

A schedule of all Assessment and Annual Reviews that informs the Personal Plan to be put in place. By 29/07/2016

A schedule of required actions, person responsible and timescales arising from assessments, personal plans and reviews will be maintained for each resident to ensure all actions are followed up as required. These will be monitored by the PIC and will be form part of the quarterly review of process overseen by Management Group. By 12/8/2016

Electric toothbrush bought for resident bought and in use by 23/06/2016.

HSE physiotherapist visited on a resident on the 6th and 14th of July and was informed about residents' medical history, mobility and activities and did a detailed posture assessment. She sent a letter on the 19/7/2016 to his GP to request for further referrals to the local radiography department, a specialist orthopaedic consultant and an OT. Physiotherapist said that OT must do sensory assessments, not physiotherapists and an appointment should come through within the next three months. The OT will do the sensory assessment and a re-assessment of his wheelchair and bedrails. HSE physiotherapist liaised with the local physiotherapist on the 26/7/2016 about the mobility assessment findings and ongoing therapies.

Proposed Timescale: 12/08/2016

Outcome 06: Safe and suitable premises

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Complete the process for removal of the 19th century building and the inclusion of the refurbished unit to ensure the premises is suitable for purpose.

3. Action Required:

Under Regulation 17 (1) (a) you are required to: Provide premises which are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

Please state the actions you have taken or are planning to take:

Registration documentation has been supplied to the Registration Office. New premise is completed. The driveway, car parking space and pathway will be completed by the 5/8/2016. A Transition Plan (see attached) is made and the resident is updated about the actions that are needed to prepare the space. He will be involved in the creation of a homely environment of his choice, purchasing of new items in preparation of his move pending authorisation of HIQA. The Inspector has inspected the new premises on the 20/7/2016 and noted is it of a high standard and suitable. His support team will stay the same. A fire safety and H&S folder is prepared for the new premise. A snag list will be make and any issues sorted by 5/8/2016. As soon as HIQA has authorised the centre to go ahead with the move, the resident can move and vacate the 19th century building.

Proposed Timescale: 05/08/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Improvements were still required in the systems for the assessment of risk, to manage actions to mediate risk and for learning from accidents and untoward events.

4. Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

A review of procedure of assessment of risks of incidents will be in place by 3/8/2016. This will cover accidents, medical incidents, and challenging behaviour incidents.

Upon notification of a medication error the error will be immediately assessed for risk by a member of the management team and appropriate actions taken to address concerns and ensure there is an understanding of causes and learning from the incident to prevent re-occurrence.

All incidents will be reviewed by a PPIM within three working days.

A schedule of quarterly reviewing and auditing risk areas is in place by 22/7/2016. Summary, conclusion and any actions will be presented, discussed and finalised in management meetings in a timely fashion. For more details see outcome 14.

Landing window in one premise will have a safety measure put in place to prevent any residents going on the flat roof. By 31/7/2016.

Risk Assessment on Candles in place by 13/7/2016 and communicated to all staff by 14/7/2016.

Any Risk Assessments that for activities/ risk areas that have not been in use for 18 months will be archived. All Risk Assessments will have date and name of initial assessor noted.

The monitoring safety of bedrails and monitoring of a resident who uses bedrails at night will be reviewed before 4/8/2016 and systems will be in place 5/8/2016. Safety of bedrails will be done daily. It will be re-assessment by an OT when their referral appointment happens. (before 19/10/2016)

Timetable of staff to be on call for emergencies is in place from 7.30pm till 8am each day since May 2014.

Risk assessment and management on the absence of one resident was reviewed and the timeframe and details of staff's response were put in by 14/7/2016.

Proposed Timescale: 05/08/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The resident wishes and choice had not been considered in the implementation of personal plans for intimate care and support.

5. Action Required:

Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:

Personal Plans of all residents that receive intimate care are reviewed with the resident and gender preference and choice will be considered and documented.

Proposed Timescale: 05/08/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Systems to protect residents and respond when concerns arise were not sufficiently robust in relation to:

- staff knowledge of procedures
- implementation of procedures
- adherence to responsibilities and best practice.

6. Action Required:

Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:

New policy Safeguarding Framework adopted on the 5/7/2016 and all staff informed on 7/7/2016, emailed to HIQA on 11/7/2016. This incorporates HSE procedures and implementation of actions.

National Safeguarding Officer (who is based in the locality) has taken up the position on a full time basis since 6/7/2016. A schedule of monthly visits to our centre has been agreed with her and started on the 1/7/2016. A follow up visit took place on the 27/07/2016 to review progress and required actions. At each visit she will review and monitor all local safeguarding issues with the PIC and the Designated Officer, so implementation of best practice and procedures are adhered to.

A review of safeguarding procedure learning arising from the inspection has taken place with staff to strengthen staff knowledge, adherence to responsibilities and implementation of best practice. Date 1/7/2016. A further practice review meeting will take place following quarterly audit in safeguarding incidents led by PiC and National Safeguarding Officer. By 5/8/2016.

Quarterly Safeguarding review audits of the Safeguarding register will take place by our PIC and management group to ensure overview, follow up, outcomes are acted on, safeguarding plans are reviewed and closure of cases. 9/8/2016.

Local Safeguarding Register is accessible electronically by the National Safeguarding officer allowing monitoring of responses and compliance with safeguarding requirements has been implemented. Completed: 27/7/2016.

All outstanding documentation to notify to HIQA relating to Section 5 of a NF06 notification are follow up on by the 8/7/2016. A template for follow up documentation has been introduced by the National Safeguarding Officer and has been used for all local incidents since March 2016.

A draft report on a NF07 has been send the designated centre and learning points have been shared with the local management group (on 21/7/2016) and the Registered Provider Nominee. It will finalised and be send to HIQA by 3/8/2016.

A workshop on safeguarding and Zero tolerance to Abuse will be run for residents. By 8/8/2016.

Good practice guidance is available to staff and the existing policy on management of challenging behaviour will be reviewed to ensure it incorporates best practice guidance. By 14/9/2016.

Proposed Timescale: 14/09/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff and the designated officers had not received training in national guidelines for the protection of children.

7. Action Required:

Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

Please state the actions you have taken or are planning to take:

Consultation with National Safeguarding officer on protection of children training. She has been in contact with the HSE to request date for the training. PIC has also consulted with a private provider of training. The centre will avail of any training what will be available first.

Proposed Timescale: 30/09/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Systems to monitor practices in the centre were not satisfactory.

8. Action Required:

Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:

Annual report by the Register Provider Nominee sent to HIQA on the 11/07/2016

Unannounced inspection by the Register Provider Nominee has happened on the 28th of June and the report including actions and timescales have been received by the PIC and the local management group. Out of the 13 actions, nine have been done, other have started and will be done in the set timeframe. Most actions are overlapping with the HIQA inspection report.

A procedure of assessment of risks of incidents will be in place by 3/8/2016. This will cover accidents, medical incidents, and challenging behaviour incidents.

A schedule of reviewing and auditing risk areas is in place by 22/7/2016. Summary, learning and any actions will be presented and discussed in management meetings in a timely fashion and quarterly reviewed as per schedule below

Review/ audit of all registers & logs

- Accidents- near misses
- Quarterly notifications & any 3 day notifications & follow up
- Risk registers
- Medical incident
- Safeguarding incidents
- Behaviour that is challenging incident
- Complaints
- Residents' assessments & annual reviews
- Residents' Finances (National audit)
- H&S (external audit)
- Training
- Medication management (national audit)

Timeframe:

Accidents - near misses January April July October

Quarterly notifications & any 3 day notifications and follow up January April July October

Risk register January April July October

Medication incidents February May August November

Safeguarding incidents February May August November

Challenging behaviour incidents February May August November
Complaints March June September December
Residents assessments & annual reviews March June September December
Finances (DA) March September
H&S March September
Training March June September December
Medication management January July
For more systems to ensure a safe service, see actions mentioned at outcome 7 and outcome 8.

Proposed Timescale: 22/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The process for ensuring all staff including the person in charge could carry out their function satisfactorily were not effective.

9. Action Required:

Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements 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.

Please state the actions you have taken or are planning to take:

Staff line management supervision has been implemented for all staff, including the PIC since 14/7/2016. A schedule of formal supervision meetings for the PIC with the Register Provider Nominee has been agreed on a 6 weekly rota.

Proposed Timescale: 14/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Staff required some additional training in the specific healthcare needs of some residents.

Some staff members required training in the use of emergency medication.

10. Action Required:

Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Emergency medication training for staff in happening on the 4/8/2016 and will be refreshed in a timely manner.

All staff will have received updated medication training by 8/8/2016.

Proposed Timescale: 08/08/2016