

**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-0003610
Centre county:	Wexford
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):	Rachel McCarthy
Type of inspection	Unannounced
Number of residents on the date of inspection:	24
Number of vacancies on the date of inspection:	2

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 2 day(s).

The inspection took place over the following dates and times

From:	To:
19 July 2016 09:00	19 July 2016 07:00
20 July 2016 08:30	20 July 2016 15:30

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

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 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the fourth inspection of this centre. The registration inspection of the centre had taken place on 16 September 2015. Due to the findings of that inspection the registration inspection did not progress and a follow up inspection was undertaken in March 2016. While improvements were evident at that inspection further actions were required in order to meet the regulatory requirements for registration.

There were three major non-compliances found at the March inspection. These were in significant areas such as safeguarding, fire safety and notifications.

As a result of concerns regarding overall safeguarding systems and responses within the organisation, the provider was requested to attend a meeting with HIQA in April 2016. 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. The actions identified in this plan were also reviewed as part of this inspection.

How we gathered our evidence

Inspectors met with residents and staff and observed practices. The residents who could communicate verbally with the inspectors told of the activities they took part in, the parties they attended and showed the inspectors their bedrooms. They said they liked their staff, they looked after them well and they often had fun with the staff and other residents. They said they went to their doctor regularly and staff helped them with this and with their medicines. Other residents allowed the inspectors to sit in their homes and observe the day to day routines.

Inspectors also reviewed documentation including policies and procedures, personnel files, health and safety documentation, resident's records and personal plans.

Description of the service

The statement of purpose describes the service as providing long-term residential services to adult male and female residents with moderate intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviours. The maximum number of residents is 28 and on the day of inspection there were 25 residents in the centre. One person was in the process of transition to live in the centre. It is located in a rural coastal setting with working gardens and a farm attached and within easy access to a local town.

Overall judgement of our findings

The actions required following the previous inspection which took place in March 2016 were reviewed. A total of 17 actions were identified with a significant number of these relating to fire safety, safeguarding and governance. Of this number significant progress had been made in all areas including safeguarding and fire safety and risk management. Governance systems were improved.

Inspectors were informed that a crucial aspect of the providers safeguarding plan had been completed with the recent appointment of a national fulltime safeguarding officer. The additional management structure required nationally had not as yet been implemented.

Overall, inspectors were satisfied that the provider had commenced putting systems in place to meet the regulations. This resulted in positive outcomes for residents in most instances, the details of which are described in the report.

Good practice was identified in areas such as:

- Health care and medicines management systems which maintained residents' safety and quality of life (outcomes 11 & 12)
- Access to meaningful recreation and activities, access to allied health and social care assessment and interventions (outcome 5)
- Regular reviews of residents personal plans (Outcome 5)
- Prompt and effective responses to allegations of abuse or misconduct which promoted residents safety (Outcome 8).

Inspectors found that the systems for oversight resulted in some risks to residents in the following areas:

- Risk assessment and management procedures (outcome 7)
- Access to suitable behaviour management assessment and interventions to ensure residents needs could be met in the centre (Outcome 8)
- Monitoring of staff practice (outcome 17)

The reasons for these findings are explained under each outcome in the report and the regulations that are not being met are included in the Action Plan at the end.

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 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):

No actions were required from the previous inspection.

Findings:

There were no actions required from the previous inspection. The inspector was satisfied that, for the majority of the residents, the centre was suitable to meet their needs, that assessments had been undertaken which informed the care provided and that the personal plans were reviewed for effectiveness and positive outcomes for the residents.

However, it was not apparent that all resident's needs could be met in this environment. This is despite the commitment of the provider demonstrated by the provision of a significant number of additional staff and the amalgamation of one unit to support residents' with higher levels of dependency. This finding is influenced by the absence of the required clinical psychology and behaviour assessment for a resident with complex needs.

Inspectors were informed that consideration was being given to seeking an alternative placement. The matter of the suitability of this placement and the absence of a comprehensive assessment which would inform such a decision was discussed with the person in charge. This finding is also discussed in outcome 8 Safeguarding.

Inspectors reviewed five residents' records and in these found evidence of multidisciplinary assessments including speech and language, occupational therapy, physiotherapy, psychiatry and general healthcare. There were also a range of evidenced based assessment tools for pertinent issues such as weight and nutrition, falls or skin integrity. Additional assessments such as occupational therapy had been sourced where residents changing needs indicated that this was required.

There were detailed personal plans available for the residents' which were in the main reflective of their assessed needs and in most instances the quarterly internal reviews indicated that the plans made were being monitored to ascertain their effectiveness and implementation. Families and or representatives were clearly involved in these processes.

A resident was in the process of transition at the time of the inspection and an assessment had been undertaken to ascertain the suitability of the placement for the resident.

Inspectors saw and residents confirmed that they continued to enjoy meaningful activities and choice in their daily lives. Residents social care needs were very well supported with a significant number of activities, meaningful daily routines and occupation available. They participated in the life of the units and shared tasks with staff including housekeeping; they worked in the gardens and on the farm and the kitchens. They had social activities outside the centre and had significant freedom of movement on the campus.

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):

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

Findings:

The action from the previous inspections in relation to the adaptation required for a resident's bathroom had been completed. An occupational therapy assessment had taken place and suitable seating and hand rails had been installed. Some further changes had been made to the units with the creation of two separate self contained units in one of the houses. Both of these were suitably laid out and equipped. They were accessed via the house. Works on upgrading of other bathrooms and areas of the premises was ongoing.

Judgment:

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 6 actions required following the previous inspection and significant progress had been made on all issues. However, some improvements were still required in the consistent assessment and management of risk. This is evidenced by the following: Fire drills had been undertaken regularly in all units. However, where the need for support with evacuation was greatest the drills had not included four of the waking night staff.

The process outlined for one resident was not suitable as it required the use of a hoist which took considerable time. Inspectors were informed however, that a fire safety consultant was in the process of reviewing this unit to advise on the most suitable systems for evacuation including equipment and identified exits.

In addition to this, staff had not had training in the management of choking incidents although this training was scheduled. While such an incident had not occurred a number of the residents had risk assessments in relation to this. The person in charge agreed to remedy the fire training within one week and the management of incidents of choking in August 2016.

Inspectors noted that a new resident in transition to the centre had a pre-admission assessment which identified self-harm as a significant potential risk. Despite spending three nights each week in the centre there was no corresponding risk management plan in place in relation to this and staff could not outline the strategy to inspectors.

The priority fire safety works which included the provision of fire doors and containment compartments were in the process of being implemented within the time frames agreed, with three units fully completed. The second phase of these works had been costed and was scheduled to commence. This included upgrades to the fire alarm systems. There was emergency lighting available.

From a review of training records it was seen that fire training had been undertaken for staff and further training was planned to include any newly recruited staff or co-workers. Pertinent personal evacuation plans were available for all other residents.

There were other individual risk assessments and management plans evident for issues such as falls, wound prevention, accidental injury or behaviours that challenge. Where it was deemed necessary changes to residents bedroom accommodation had been made support residents with mobility issues and promote their continued independence.

The risk management policy was in accordance with the regulations and a detailed risk register was maintained and updated. A comprehensive independent health and safety audit had been undertaken and inspectors saw that the person in charge had promptly rectified any issues identified in the audit. Internal fire safety checks were being carried out in each of the units. Maintenance records were seen for the fire alarm system, fire extinguishers and emergency lighting.

The system for learning and review from accidents or untoward events had been substantially improved. There was evidence that incidents were reviewed by the person in charge and the deputy and a register of all such events was maintained. Individually incidents were responded to and remedial actions implemented. These actions were then tracked to ensure completion and effectiveness. For example, referrals to allied services, changes to routines or additional staff support.

A detailed audit of medication incidents was undertaken by the person in charge. This was a comprehensive review of all of these incidents which clearly identified causal factors and the precise units in which they occurred. Remedial actions taken included changes to the location of the medication storage systems and additional training for identified staff.

The incident monitoring systems to be introduced across the organisation as part of the providers safeguarding plan was not yet in operation in the centre. However, inspectors were satisfied with the process implemented by the local management team.

There was a current and signed health and safety statement available.

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:

From a review of the records available in the centre and notifications forwarded to the Authority inspectors saw significant improvements in the process for recognising and responding promptly to any concerns or allegations of abuse or misconduct made. The person in charge had taken prompt and immediate actions to both protect residents and deal with potentially abusive behaviours.

However, the action in relation to the assessment and availability of specialised behaviour supports was partially but not fully addressed. A number of residents had been reviewed by clinical behaviour specialist and this resulted in revised behaviour support plans and daily routines. However, a resident identified at the previous inspection with significant and complex challenging and self harming behaviours had not had access to this assessment and interventions. There was evidence of psychiatric and medicines review and advice available for staff. The behaviour support and assessment recommended by the psychiatric service had not been sourced.

A significant increase in resources primarily staffing had been made available in order to support the resident. This included one to one or two to one staff and waking night staff. Other actions taken by the person in charge included the provision of a separate small apartment in one of the units to reduce the environmental impact on the resident and minimise the impact of the behaviours on the other residents.

The incidents reported as seen by inspectors were of a serious and prolonged nature. From the records available and interviews inspectors found that the person in charge had considered the possibility that unresolved pain may have been factor in the behaviours. To this end staff were required to maintain detailed records of the administration of pain medication, presenting behaviours and its affect.

These were not maintained adequately by all staff. In addition, despite detailed incident forms the triggers or precipitating factors were not noted sufficiently to facilitate a robust assessment. Immediately following the inspection the person in charge informed HIQA in writing that this specialist assessment and behaviour supports had been sourced. There were some gaps found in training in the management of behaviours that challenge with 11 employees and seven volunteers who were not detailed as having this training.

These factors coupled with the lack of behaviour supports did not demonstrate that every effort to alleviate the causes of behaviours was being made. Inspectors acknowledge the commitment of staff and the person in charge to the resident. Further aspects of the suitability of the centre to meet the resident's needs have been detailed and actioned under outcome 5 Social Care needs.

It was apparent that in other instances small but very significant improvements had been made as a result of behavioural supports available. For example, a resident was slowly reintegrating with other residents and general activities and therefore experiencing a better quality of life.

A small number of restrictive practices were used including audio alarms and or door sensors. The register of use was not correct and not current or known by staff in the

unit. While the rationale for the use of the practices were clear and it was primarily to protect other residents, there was no evidence of adequate review, trials of alternatives, effectiveness or multidisciplinary involvement in their use. There was evidence that medication was not used to manage behaviours.

Procedures for responding to any allegations of abuse or misconduct had improved. There was evidence that screening of any allegations was undertaken and where appropriate reports were made to the organisations case management team for either investigation or advice. There was also evidence that the Health Service Executive (HSE) was informed as required.

Following the previous inspection HIQA had concerns as to the procedures used and as a result the findings issued in regard to one such allegation. The provider's action plan had indicated that this process would be reviewed. This had not occurred at the time of the inspection. Immediately following the inspection the person in charge confirmed in writing that arrangements had been made to have this undertaken by a person external to the organisation.

Where recommendations had been made by the national team inspectors found that they had been acted upon. This included additional training for staff in appropriate boundaries with residents.

The person in charge and the designated person for the protection of vulnerable adults had been trained in the revised HSE policy on the protection of vulnerable adults and both were found to be knowledgeable as to their responsibilities. Staff had also been provided with safeguarding training. The benefit of this was evident in how an incident of peer to peer physical abuse and lack of appropriate staff response was raised to the person in charge.

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 in safeguarding. The implementation of a national monitoring system for responses and compliance with safeguarding requirements was not available to the person in charge or the inspectors. The inspectors were informed that the agreed appointment of a fulltime national safeguarding officer to oversee and support the actions of the local managers and ensure investigations were managed satisfactorily had been completed.

Policies were in place for managing residents' personal property and finances. The majority of the residents required staff support with the finances. In each unit there were transparent details and records of spending on behalf of residents. While inspectors found no evidence of any untoward spending or usage of residents monies the systems for oversight of this were not formalised. The providers safeguarding plan indicated that formal financial auditing systems would be implemented in the organisation but this had been delayed.

Advocates had been sourced for a number of residents who required this.

Residents who could communicate informed inspectors that they felt very safe and well cared for in the centre and they liked their staff. From observation staff were respectful and supportive of the residents.

Judgment:
Non Compliant - Moderate

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

Findings:
Inspectors found that the person in charge had complied with the responsibility to forward the required notifications to the Chief Inspector.

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. Residents healthcare needs were reviewed at a minimum annually and as required. There was good access to 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 residents' health. Where a specific care plan for health care needs was required it was implemented including plans for skin integrity, catheter and stoma care. Staff were familiar with the

plans and told inspectors about them. A turning regime was in place for one dependant resident. A resident had recently been diagnosed with a long term illness and inspectors found that the house co-ordinator had ensured she was familiar with the diagnosis and the purpose of the required medication.

In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists, neurologist and other specialists including dentists and chiropradists. Records of referrals and reports of these interventions were maintained in residents' files.

There was evidence that where treatment was recommended and agreed by residents this treatment was facilitated. Residents' right to refuse medical treatment was also respected.

There was evidence on documentation that residents and their representatives were consulted about and involved in the meeting of their own health and medical needs. A protocol was in place for the management of epilepsy and the use of emergency medication and staff outlined this to inspectors.

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. Residents helped to prepare the food with staff assistance where this was necessary and had full access to the kitchens and catering equipment in the houses and the apartments.

Where specific dietary needs or support with eating and drinking were identified by dieticians these were seen to be adhered to by the staff. Fluid charts were maintained as dictated by the resident's medical condition and the directions of speech and language therapists were adhered to.

Adapted crockery and utensils were seen to be used as necessary to encourage independence. Inspectors observed that residents were encouraged and enabled to make healthy living choices in relation to exercise and healthy eating habits.

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 including waking night staff. Equipment such as pressure relieving mattresses, 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. The person in charge had supported a resident at end of life care successfully and sourced appropriate palliative and external supports.

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:

Inspectors found that medicines management systems were satisfactory. There was a centre-specific medicines policy that detailed the procedures for safe ordering, prescribing, storing administration and disposal of medicines and these were seen to be adhered to.

Most medicines were dispensed in blister packs. There was identification of medication on each of the medication dispensing blister packs. In a number of units the co-ordinators were found to be very vigilant in response to any medication errors or incidents with very regular auditing of stocks taking place.

There were protocols in place for the use of emergency medication and sufficient staff had been trained in its usage. The protocols were also available in the workshops used by the residents. Inspectors were informed that no residents were assessed as being able to manage their own medication at the time of the inspection. Training had been provided to staff/co-workers on general medication management.

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):

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

Findings:

The actions from the previous inspection had been partially resolved. There was evidence that the person in charge had taken appropriate steps in relation to the provision and monitoring of staff training, oversight of practices, safeguarding and the progression of the fire safety management works. However, findings in relation to the workforce indicate that further development of roles and responsibilities for staff and all persons with responsibility is required in order to ensure the care provided is safe and suitable.

In two units staff did not have the sufficient knowledge of resident's healthcare status, risk assessment, review status or awareness of overall care needs which would be expected. This could impact on resident's welfare and care provision.

Inspectors also observed that for a period of 45 minutes on the evening of the first day of inspection there were no staff available for the three residents in the unit. This absence was not planned and the residents thought one staff may have been upstairs but inspectors could not ascertain if this was the case.

A similar incident had been previously reported to HIQA by the person in charge who took appropriate action. While on this occasion there was no ill effect to the residents the expectation of staff responsibilities and duties requires a review. It could also have placed the residents at risk from unauthorised persons accessing the centre.

The local management roles and responsibilities were clearly defined. The person in charge was seen to be very involved in the day to day governance of the centre. While residents did not require fulltime nursing care her involvement as a nurse with considerable relevant experience was evident.

Staff were very clear on the reporting structures and the communication systems were effective and helpful. Weekly local management meetings continued to ensure consistency and development of practices in the centre.

There was a direct line management supervision system evident between the provider nominee and the person in charge. The deputy person in charge was also fully involved in supporting the person in charge with clear delegation of responsibilities.

The nominee of the provider demonstrated an awareness of the responsibilities of the role. As required by the regulations the provider arranged an unannounced visit to the centre in April 2016 and a detailed report was available with issues identified such as management of resident's finances, behaviour supports and resident's general welfare.

Inspectors were informed that a resident's survey was in the process of being undertaken and a survey for relatives had been completed but was not as yet analysed. The annual report was not available to the inspector at the time of the inspection but was forwarded following the inspection. There were satisfactory audits of practices, accidents or incidents undertaken to inform practices and changes.

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):

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

Findings:

The workforce in the centre was a combination of volunteers, co-workers and employed staff, a number with social care qualifications.

The provider had in the preceding months increased the number of paid staff available and one to one supports for residents had been sourced. These were primarily deployed to one unit where the highest dependency and complexity of need had recently been amalgamated.

Due to the number of units and the reliance on the volunteer system as per the provider's care provision model there were co-ordinators appointed to each unit to undertake the day-to-day care and planning and oversight of the teams. Systems for the formal supervision of staff were ongoing but the findings detailed in outcome 14 indicate that further structures for ensuing accountability and adherence to duties were required.

From the training records made available inspectors found that mandatory training in moving residents, safeguarding and fire management had been provided. However, there were some gaps found in training in the management of behaviours that challenge with 11 employees and seven volunteers who did not have this training. First aid training was provided and further training was seen to be scheduled.

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

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

Health Information and Quality Authority Regulation Directorate

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-0003610
Date of Inspection:	19 July 2016
Date of response:	13 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 05: Social Care Needs

Theme: Effective Services

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

A comprehensive assessment of needs was not carried out.

1. Action Required:

Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and

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

social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

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

A comprehensive assessment will be carried out by the PIC to reflect the changing needs of the resident.

Proposed Timescale: 19/08/2016

Theme: Effective Services

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

It was not demonstrated that the centre could meet the assessed needs of a resident.

2. Action Required:

Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

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

A case conference is being held with the HSE regarding alternative placement for this resident on the 1 Sept 2016.

A psychological and behaviour assessment will be carried out through accessing MDI input from behaviour specialist Studio 3 within the month of August. The resident's Personal Plan, associated training and development of a transition plan will be informed by this to ensure resident's needs are met.

Proposed Timescale: 30/08/2016

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:

Systems for the management of identified risks were not consistently implemented including but not exclusive to potential accidents or self harm.

3. 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:

The general and individual risk assessments will include the management of all identified risks including potential accidents and self-harm. These will be included on

the risk register.

One residents' risk assessment for self-harm has been amended to reflect this more clearly.

Fire drills will continue to be undertaken regularly in all units and the practice will make provision for the inclusion of the waking night staff in such drills.

Scheduled training for staff in the management of choking will be undertaken as planned.

Proposed Timescale: 16/08/2016

Theme: Effective Services

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

Dedicated night staff had not participated in fire drills to ensure they were familiar with the process of evacuation and fire management.

4. Action Required:

Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

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

All dedicated night staff have participated in fire drills and are familiar with the process of evacuation and fire management.

Proposed Timescale: 12/08/2016

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:

There was insufficient evidence that every effort to alleviate the causes of behaviours and intervene to address the behaviours was being made.

5. Action Required:

Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

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

All personnel will be trained in completing and maintaining incident reports more effectively to indicate triggers and causes of behaviours to enable learning around behaviour, reducing behaviours that challenge and dealing with them when they do.

The use of restrictive measures for one resident has been reviewed internally and the care plan updated to reflect actual measures and all personnel informed.

The plan for the use of restrictive measures will only be implemented following MDT review and documented plan outlining that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Proposed Timescale: 12/08/2016

Theme: Safe Services

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

A number of staff did not have training in the management of behaviours that challenge.

6. Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

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

An outside training company have confirmed they will conduct an assessment, behaviour support plan and training for employees. We are awaiting confirmation of date for this to occur.

Proposed Timescale: 31/08/2016

Theme: Safe Services

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

There was insufficient evidence of adequate review, effectiveness or multidisciplinary involvement in the use of restrictive practices.

7. Action Required:

Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

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

Current restrictive practices will be reviewed and this will include a review of the register of usage to ensure it is correct, current and known to relevant staff. Trialling of alternative options will be considered and implemented where deemed suitable. Any requiring MDT involvement will be sought and documented.

Proposed Timescale: 26/08/2016

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:

Some staff did not have sufficient knowledge of residents care needs and there were no staff available to the residents in one unit for a significant period of time during the inspection. This was not a planned absence.

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:

A meeting will take place with all house co-ordinators regarding roles and responsibilities including having a thorough awareness and knowledge of the residents care needs.

A review of staffing in two houses has been undertaken since the inspection and changes made in the management personnel within the houses.

Staff are being spoken to in the two units to ensure they have sufficient knowledge of the residents' healthcare status, risk assessments, review status or awareness of overall care needs expected.

An incident learning notice was developed and forwarded to the regulatory body regarding residents being left alone. This was shared and discussed with all house co-ordinators. The learning from this was subsequently shared nationally with colleagues via discussion at the Collaborative Learning Group.

The house co-ordinator was spoken to individually. The learning piece outlines measures to prevent reoccurrence.

Proposed Timescale: 11/08/2016

Theme: Leadership, Governance and Management

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

At the time of this inspection there was no annual review of the quality and safety of care.

9. Action Required:

Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

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

The annual report had been conducted at the time of inspection but was not made available to the inspector. A copy of the Annual Report has subsequently been forwarded to the Authority

Proposed Timescale: 02/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

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

Supervision arrangements for staff were not satisfactory to ensure they carried out their duties effectively.

10. Action Required:

Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

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

A meeting will be had with house co-ordinators regarding roles and responsibilities including having a thorough awareness and knowledge of the residents care needs.

A new national policy on line management supervision and appraisal was approved by Council on the 04/08/2016 and this policy will be rolled out in all supervisions within the Community.

The PIC will ensure greater supervision of staff to ensure they carry out their duties.

Proposed Timescale: 02/09/2016

Theme: Responsive Workforce

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

A significant number of staff did not have training in the management of behaviour that challenges.

11. 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:

Training is being held on 12 August 2016.

An outside training company will also be providing some training in the month of August.

Proposed Timescale: 31/08/2016