Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Camphill Community Kyle
Centre ID:	OSV-0003625
Centre county:	Kilkenny
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Camphill Communities of Ireland
Lead inspector:	Noelene Dowling
Support inspector(s):	Gary Kiernan Laura O Sullivan
Type of inspection	Unannounced
Number of residents on the date of inspection:	16
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 Representation received 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 April 2018 10:00	19 April 2018 19:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the 6th inspection of this centre undertaken in order to make a final determination of the registration status of this centre.

The centre had significant changes at management level since the first inspection in 2015. This resulted in a lack of consistent governance and stability, which affected residents' wellbeing and safety.

Following the findings of the last monitoring inspection in September 2017 and evidence of lack of capacity of the provider to operate a safe and well governed service a notice of proposal to cancel and refuse the registration of the centre was issued by HIQA on 21 November 2017. The notice focused on governance protection of residents and staffing arrangements. As part of the regulatory process, the provider was given 28 days to respond to this notice and outline the actions they intended to take to being the centre into compliance.

The provider’s response to the notice was detailed and satisfactory. As a result, the Chief Inspector requested that a further inspection be carried out to ascertain if these actions plans had been carried out and if they were effective.

How we gathered our evidence:

Inspectors met with 5 residents, a number of staff, the interim person in charge,

deputy managers and regional manager. Practices were observed.

Residents who could communicate told inspectors they felt very happy and safe living in the centre and that where they had raised issues these were addressed with them.

They said they choose their own activities, daily routines or work and enjoyed doing these. They said they had good access to health care and social events and staff helped them to do these things.

Other residents allowed inspectors to observe some of her daily lives and communicated in the own preferred manner. Inspectors observed that they were relaxed in their interactions with staff, and staff were engaging very well with the residents.

Inspectors also reviewed documentation including resident's personal plans, safeguarding plans, financial records, personnel files, supervision record, and management meeting records, and incident reports.

The seven actions from the previous report were also reviewed.

Description of the service:

The statement of purpose states that the service is designed to provide long-term residential services for adults, both male and female with moderate intellectual disability, people on the autism spectrum, physical disabilities and challenging behaviors. Fulltime nursing care is not provided or required by the residents. Some nursing oversight is available on a part time basis. The service and care provided was congruent with this statement.

Service is provided to 17 residents in six residential units, accommodating between five and one resident and varying numbers of short-term volunteers who live in the units for agreed times. There were 16 residents living in the centre at the time of the inspection.

Summary of findings;

The actions required following the previous inspection, which took place in September 2017, were reviewed. Seven actions were identified and five of these had been satisfactorily addressed. A number but not all of the provider actions as outlined in the response to the notice of proposal had also been completed. Progress had been made however in all areas.

It is acknowledged that significant work had been done and resources deployed to achieve this and it was seen to have beneficial effect on the residents' welfare and safety.

There were improvements evident in the following:

• more effective local management arrangements;
• additional employed staff
• systems for monitoring of practices and untoward events
• more robust and effective local reporting arrangements
• additional training and supervision of staff and volunteers,
• access to meaningful recreation, activities and multidisciplinary assessments, and interventions which supported residents‘ quality of life (outcome 5)
• suitably qualified skill mix and numbers of staff with further increases being planned

Good practice was also identified in areas such as:

• healthcare needs and medicines management, which ensured residents' safety and wellbeing (outcome 11 & 12)

Some improvements were still required in the management systems to ensure the service is effectively monitored and remains so consistently. Areas for improvement included:

• the appointment of fulltime person in charge
• more robust quality review and oversight by the national management team
• appropriate responses to safeguarding matters
• clarity and oversight of the roles of the volunteers and suitable living arrangements for volunteers.

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):
No actions were required from the previous inspection.

Findings:
While this outcome was not reviewed in its entirety, there was evidence that residents were being consulted regarding her preferences for day services, activities and routines. Advocates had also been sourced and were actively supporting residents with specific decisions regarding their care or finances.

Residents were being consulted individually and in meetings where this was appropriate and inspectors saw that issues they raised such as accommodation were addressed via the improved reporting systems, which were evident.

While there were some examples of complaints being documented and promptly responded to, some further improvement was needed. Some concerns raised which constituted complaints regarding care had not been managed via this process but inspectors could not ascertain the reasons for this.

Staff were also actively reviewing the daily routines with residents to ascertain if they remained suitable or if the residents would enjoy other experiences.
Throughout the inspection, staff members were seen engaging with residents in a respectful, caring and relaxed manner.

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:
The actions required from the previous inspection had been satisfactorily addressed and improvements were evident.

There was evidence of an increased focus on residents' individual needs and preferences. Re-assessments were taking place to ensure the care provided was in accordance with their identified needs. Specific assessments and implementation plans for sensory and other supports had been sourced and were being implemented to residents benefit. Identified staff were being trained by the clinicians in the implementation of these plans for residents benefit.

Identified key workers had been assigned with responsibility for oversight of residents care needs and ongoing reviews. The increase in employed stable staff supported this process.

Annual and more frequent reviews were being held with and on behalf of the residents. Inspectors saw that these were comprehensive evaluations of residents, informed by the allied assessments and the resident's preferences. Further aims and goals were identified at these reviews for resident's health and social development. Person plans were detailed and pertinent to the residents assessed needs.

Families and or representatives were involved and consulted regarding these plans. Introductions to other and more varied and external activities and day services were being trialled with residents. There was an increase in access to external activities and services evident.

Residents had good access to local communities for social events of their own choosing, and access to external facilities for example swimming pools, restaurants, beauticians, on a regular basis.

Inspectors were satisfied that the centre could meet the needs of the residents and was continuing to identify needs and plan these.

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

Findings:
The actions required from the previous inspection had been addressed.

Inspectors found that that risk management processes and systems were satisfactory. The fire safety training and evacuation process for the volunteers had been provided to ensure they were familiar with these and could respond appropriately. Regular fiire drills were held in each unit and the length of time taken to evacuate was recorded and monitored. Fire safety equipment had been serviced and maintained as required.

Residents had individual risk assessments governing the pertinent risks including falls , accidental injury , self-harm, road safety. These were updated as necessary as was the risk register to ensure this was an ongoing and responsive process. The register was detailed, relevant to clinical and environmental risks in place with suitable control measures implemented.

Inspectors reviewed the accident and incident register and noted an improvement in the systems for reporting and responding to such incidents locally. These were risk rated and reviewed to ensure any additional control measure was put in place and these were monitored.

Judgment:
Compliant

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:
Inspectors found overall that the failings in safeguarding were being recognised and systems implemented to address them. However, some improvements were still required to ensure residents' needs for protection were recognised and the appropriate systems and controls were known and understood within the organisation.

A significant and complex safeguarding matter had been reviewed via a multidisciplinary framework inclusive of all relevant agencies. This was required following the previous inspection and had been carried out. However, no safeguarding plan was implemented to ensure the resident's personal safety from potential risks in and outside of the centre and this meant that some potential risks to the resident had not been planned for.

In general the provider had put improved systems in place to protect residents' finances. However, a further safeguarding plan was required to ensure the actions taken by the provider in relation to residents finances were adhered to and protective. This latter was addressed during the inspection. In addition intimate care plans seen did not address specific risks or vulnerabilities identified.

The provider was acting as agent for the finances of a number of residents. The systems in the units were detailed and transparent for day-to-day management of resident's monies. However, there was no system evident or made available to inspectors for oversight of the provider's systems in such cases. This had also been required following the previous inspection.

Inspectors found that peer-to-peer issues were now being managed appropriately.

In the response to the notice of proposal the provider stated that appropriate staff would be trained in undertaking "Trust in Care" investigations in accordance with accepted safeguarding norms. The provider also undertook to ensure that there would be a clear reporting and response process to such incidents. The person in charge was appropriately trained in this area and had commenced providing this training to key staff. Relevant safeguarding issues were reported to the person in charge. However, oversight and response to these by senior managers was not evident to inspectors. This was an area for improvement in order to ensure incidents were managed well with accountable structures, reporting and response mechanisms from the provider evident.

The designated officer had been appointed but had not yet had the required training in this area in order to fully take up their role .However, in the meantime, it was evident that the person in charge oversaw all such matters which provided a level of assurance that there was appropriate oversight.

Additional training for staff in both safeguarding, and more focused training on the support of residents with behaviours that challenge was evident. This training was continuing with ongoing advisory support to staff. Incidents were responded to and reviewed appropriately locally.

Individual psychological and specialist behaviour supports for residents had also been sourced. However, one resident with such behaviours did not have a support plan to guide staff. Inspectors were advised that this was being developed under the guidance of the behaviour specialist, which is satisfactory.
Practices in the units including behaviour support and day-to-day care were being monitored by one of the deputy managers.

The provider had undertaken a self-audit in safeguarding at the request of the of the HSE in late 2017. This was in response to concerns which had been identified in a number of centres operated by the provider. From a review of the audit it was completed transparently and with due regard to the deficits in the systems.

The increase in the number of trained staff also ensured that the work of the young volunteer / co-workers was supported and monitored more appropriately.

Judgment:
Non Compliant - Moderate

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:
Residents' healthcare needs, including nutritional needs, were identified and monitored with good access to appropriate medical and allied healthcare services. Regular medical and medicines reviews were evident.

In line with their needs inspectors were satisfied that residents had ongoing access to allied healthcare professionals including speech and language therapists , physiotherapy, neurology, dentists and chiropodists and age and gender specific related services.
Further referrals to allied services were identified and seen to be in progress.
Suitable support plans were available for all identified needs including skin integrity, dietary needs and falls risks. Staff were able to outline these to the inspectors.

There was evidence and residents confirmed that they and their representatives were consulted about, well informed and involved in the meeting of their own health and medical needs in as much as possible.

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:
A number of actions were required following the previous inspection to ensure the management arrangements were sufficient to support the quality and safety of care. These related to the stability of the post of person in charge and safe effective oversight arrangements in the centre. While improvement had been made these actions had been partially but not fully completed.

The provider's arrangements for the role of person in charge were not satisfactory. The person in charge, though qualified and committed to the role was responsible for this and one other centre. While the person in charge demonstrated competence to carry out the role and was supported by two deputies, the requirement to manage two centres was not a sustainable arrangement. This issue had been identified by the provider and recruitment campaigns were underway.

There was evidence of significant intervention at local management level with improved reporting and planning structures evident. The arrangement was temporary however and is not sustainable for one person to safely and effectively manage two such units in the long term.

In addition to this, two suitably experienced deputy managers had been appointed. One of these had specific responsibility for direct care and oversight or practice in each unit and the other for oversight of complaints, and safeguarding under the direction of the person in charge. The positive impact of this was evident in the outcomes on social care, access to therapeutic programmes and re-assessment of resident needs.

There were formal, effective and timely reporting and response systems evident at local levels. Focused management and resident's welfare meetings took place with a detailed weekly report to the person in charge to ensure relevant information was known and acted upon as needed.

Some improvements were still required however in ensuring the governance

arrangements, systems for oversight by the provider were sufficiently robust, and to ensure arrangements remained safe, suitable and sustainable.

The post of regional manager had been filled with a view to strengthening supports and oversight as a key factor in promoting accountability in the organisation. However, in practice, while there was evidence of increased support and supervision of the local management team some crucial strategies were not implemented effectively. These included unannounced provider inspections and systems for effective reporting to the provider's quality and safety committee and safeguarding committee. Robust auditing systems had not been devised although the person in charge stated that this was in process.

In addition to this, inspectors were concerned that a crucial directive from the governing body regarding the off duty living arrangements for the volunteers had not been implemented in its entirety. Given that this centre was one of those in which this had been a significant risk, inspectors were not assured that this matter had being given due consideration.

Inspectors reviewed the provider's actions taken in response to a very significant event, which had occurred in the centre in relation to volunteers. The review indicated that there were deficits in the actions taken at the time to ensure that the behaviours of the volunteers were governed by unambiguous and monitored rules of conduct. It was of concern that supervision records reviewed in relation to this did not demonstrate that this had been addressed in an appropriate and ongoing manner.

This matter required review to ensure there is sufficient organisational learning and understanding should such an indicant occur again.

Arrangements detailed in the provider's response for duty managers on the campus remained ambiguous in practice, as the duties had not been clarified in terms of oversight of units. The deputy managers predominately work 9- to 5 weekday hours and this required review to ensure management presence in the centre was sufficient. Staff however commented positively on the improved systems for management and support.

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 actions from the previous inspection had been partially resolved and further recruitment of staff was ongoing to support better consistency and care delivery to residents. This would ensure there was a coordinator with responsibility in each unit. There were significant improvements in the staffing levels and qualified support available to the residents with up to eight additional qualified personal employed although further staff was required to ensure full capacity.

The numbers of volunteers had significantly reduced and core care needs were being primarily delivered by employed staff with the young volunteers having a greater level of support and supervision.

In addition, the person in charge informed the inspector that the intake of the volunteers for 2018 was planned to be staggered to minimise the disruption to the residents and their care needs, which had a significant impact on resident at the previous inspection.

Deployment arrangements were made according to the support needs of the residents and to ensure there was a qualified staff on duty at all times.

There were improved effective systems for oversight and support of both staff and volunteers with focused and pertinent supervision now taking place.

Inspectors found that the numbers and skill mix in this instance was satisfactory and Inspectors reviewed a sample of staff files and found that the required documentation as per Schedule 2 and safe recruitment including police clearance from other jurisdictions
All mandatory training and training needs identified by the previous inspection had been undertaken.These-included training in behaviours that challenge, sensory supports and fire safety.

Inspectors spoke with staff during the inspection. They found that staff had the required knowledge and skills to support the residents in their daily lives and were enthusiastic about the revised governance and support arrangements. Staff were knowledgeable regarding the resident's needs and preferences.

Judgment:
Substantially Compliant

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 report[1]

Centre name:	A designated centre for people with disabilities operated by Camphill Communities of Ireland
Centre ID:	OSV-0003625
Date of Inspection:	19 April 2018
Date of response:	10 September 2018

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 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that matters raised which constitute complaints are managed transparently via the process.

1. Action Required:
Under Regulation 34 (2) (b) you are required to: Ensure that all complaints are investigated promptly.

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

Please state the actions you have taken or are planning to take:
All complaints will be investigated promptly by 31.5.2018 and outcomes given to relevant parties. The complaints procedure was reviewed on the 21.4.2018. All staff will be trained or retrained in the complaints procedure by 20.6.2018

Update 10.09.18:
All staff have received Complaints training by the 20th of June, except two staff due to annual leave, but have since done the training. The newest recruited staff and coworkers are scheduled to be trained. Complaints training is part of all staff and co-worker induction and is ongoing. Complaints policy reviewed
All outstanding complaints have been followed upon by the end of April 2018. All new complaints have been dealt with and we have no current outstanding complaints outstanding. Audit review on complaints for quarter one and quarter two are done and actions identified and in process.
Actions all done

Proposed Timescale: 20/06/2018

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Safeguarding plans were not implemented to address the specific and pertinent risks to some residents.
Safe arrangements for oversight of the management of resident finances were not demonstrated in all cases.

2. 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:
All existing safeguarding plans are reviewed and outstanding plans will be in place by the 1.6.2018. Guidelines on how to support residents with their finances will be drawn up by 1.6.2018. Weekly spot check on one of the residents' DA finances has commenced per February 2018, documented on the weekly report to Regional manager Guidelines for oversight of Provider for residents that Provider is acting as an agent for are written up 6/6/2018.

Update 10.09.18:
All residents have up to date formal safeguarding plans regarding any safeguarding incidents, backdated for the whole of 2018.
Guidelines on how to support residents with their finances is in place and distributed to all staff.
Weekly spot check by PIC deputy is taking place, and reported to RM.
The DA finances from Residents who the Provider is the agent for is check monthly in accordance with guidelines drawn up on the 6/6/2018.

Actions all done.

Proposed Timescale: 06/06/2018

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Intimate care plans seen did not sufficiently address the specific care needs of some residents.

3. 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:
All intimate care plans will be reviewed and updated by the PIC and DO.
All intimate care plans will be easy read, discussed and agreed with each resident, including consent to individual staff supporting them by 15.6.2018

Update 10.09.18:
All intimate care plans have been reviewed and updated.
All intimate plans are made easy read and are discussed and agreed with each individual resident. All residents have been consulted in regards to individual staff members supporting them with intimate care. Easy read written consents for each staff member as per resident are in place.
All actions done.

Proposed Timescale: 15/06/2018

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
The person in charge was not in a position to provide full-time oversight and the arrangements to manage more than one centre were not satisfactory.

4. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
A full time PIC will be in place, current PIC will stay in position until a suitable candidate

has started. Internal national advertisement will be put up by 8.5.2018. External advertisement will be rolled out additionally.

Update 10.09.18:
Camphill Kyle was unsuccessful to recruit a new PIC over the last months, but a good candidate was interviewed successfully on the 6/9/2018. The new full time PIC will be in place by the 17/9/2018. The current PIC will provide an introduction and ongoing support at least until the end of 2018 to ensure a smooth transition and follow up on any actions due. Change of PIC forms sent to HIQA Registration and Inspector on 14/9/2018.
All actions done by 17/9/2018.

Proposed Timescale: 01/08/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Actions taken in response to specific issues of safeguarding concern had not been completed and did not provide assurance that re-occurrences of this nature would be managed more effectively.

5. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
In response to the specific incident that occurred late in 2017, a number of safeguarding measures have taken place.
• An organisational directive was issued in relation to no drinking of Alcohol in Designated centres, by staff and volunteers.
• We have reduced the dependency of STCW, by increasing the number of paid professional staff. The number of STCW living in Kyle going forward will be no more than 10, per year.
• The majority of STCW have moved out of the designated centres, and alternative accommodation in the community has been/ will be sourced, all will have moved out of the designated house by 5/6/2018.
• The STCW are on Rostered system with in the designated centres, so there is a clear, distinction between time off and working hours.
• All STCW receive supervision; from their direct line manager in Kyle.
• The provider recognises the specific challenges that LTCW & STCW brings for the governance of the organisation. A LTCW group was set up to review the role of LTCW in Q4 of 2017.
• The provider recognises the need to have a separate review process in place for the governance of the STCW going forward.
• The role of STCW going forward is being reviewed names are being currently sought for members of this review group.

Update 10.09.18:
Directive is continuously being adhered to. STCW number has been reduced to five since end of August 2018. All STCW have moved to accommodation outside the designated houses since June. All co-worker except one have left the community as their agreed time was finished. Kyle currently have four STCW. One more is due to arrive in October 2018.
All STCW are rosted at allocated shifts with a clear distinction between time off and working hours.
All receive supervised regularly by their house coordinators.
National review of the role of the STCW is currently taking place by the Wolfe Group, consulting with all relevant stakeholders. Report is due on by the end of October 2018.
A transition process for the LTCW is taking place by a LTCW transition group in conjunction with the board of CCoI.
All staff and coworkers receive safeguarding, children first, Trust in Care and complaints training as part of their inductions.
All action done or are in process.

Proposed Timescale: 30/09/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
Systems for management oversight in the centre were not implemented in a manner which would ensure effective and safe service delivery.

6. Action Required:
Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

Please state the actions you have taken or are planning to take:
Quarterly Audits reports to the management group and the regional manager will be in place regarding all accidents, behaviour incidents, medication incidents, safeguarding incidents, complaint, quarterly and 3 day notifications will be in place by 30.6.2018. Reports on training, supervision and appraisals to the management team and the regional manager will commence from 30.6.2018. A system to ensure resident's files updates are monitored will be in place by 30.6.2018, with reports to management and regional manager.

Update 10.09.18:
Medication incidents audits for Q1 and Q2 done and actions are being followed up. Pathway on how actions or retraining of staff relating to medication errors is put in place by management.
Challenging behaviour incident audits for Q1 and for the month of June, July and till min August are done and actions are being followed up. Audit on incidents in April and May are in process.

Accidents audit of June, July and till mid August was done and actions are being followed up. Accidents in Q1 and in April and May have been reviewed as part of quarterly notifications to HIQA. Full audits will be done by 30/9/2018.
Safeguarding incident audits for Q1 and from June, July up to mid August are done, audit on incidents in April and May are in process.
Complaints audits Q1 and Q2 were done and actions are being followed up.
3 day notification incident audits will be backdated to January 2018 and will be done by 30/9/2108.
Conclusions of the audits are shared in management and Welfare meetings and with the RM.
KPI reports to RM on a monthly basis include report on supervision taking place, staffing level. Appraisal schedule is in place. Training records are kept by management and weekly checked for training and refresher needed and training is scheduled as needed.
Spot check of residents' files scheduled weekly and reported to PIC and RM.
All HC have quarterly schedule of all document in residents' files.
Planned is a quarterly check by senior staff on all residents' files this will commence in October 2018.
All actions done or in process.

Proposed Timescale: 30/06/2018

Theme: Leadership, Governance and Management

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
No unannounced inspections had been undertaken in the centre to inform the provider of the quality and safety of care.

7. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
Outstanding unannounced inspection report will be distributed to HIQA and management by 28.5.2018. Regional Manager will schedule unannounced inspections and report for the next 3 years.

Update 10.09.18:
Unannuanced inspection report on behalf of the Provider was done sent to HIQA and PIC on the 28/5/2018. RM has scheduled unannounced inspections on behalf of the Provider to Camphill Kyle.
All actions done.

Proposed Timescale: 28/05/2018

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider (Stakeholder) is failing to comply with a regulatory requirement in the following respect:
To ensure that there were sufficient consistent staff and coordinators to provide the care required for residents.

8. Action Required:
Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

Please state the actions you have taken or are planning to take:
SOP will be updated by 30.5.2018 and as level of staff changes, by 30.6.2018 and ongoing when staff level or PIC change. On call duty manger guidelines are in place by 29.5.2018. Duty leader on site will be in place 24 hours per day from 1.8.2018. Guidelines for duty leader will be in place.

Update 10.09.18:
Updated SOP was send to HIQA on the 2/5/2018 including resignation of one PPIM and change of staffing levels, and on the 28/5/2018 with change in staffing levels.
SOP is being updated and staff changes will be put in and send on 19/9/2018 to include new PIC.
Duty manager guidelines have been drawn up by 9/5/2018 and shared with all relevant staff. This has been reviewed and updated on the 12/9/2018 and send to all relevant staff.
Duty manager is on site from Monday to Friday from 9am till 9pm and on Saturday and Sundays from 9am till 5pm. Qualified staff is overnight on sleepovers in each house since August 2018. On-call managers are scheduled for each day and night.
Duty managers are being recruited for overnights, but due to difficulties filling existing posts, these positions have not been able to be filled to date. Duty manager in place on 24 hours per day by 31/10/2018.
All outstanding actions will be done by 31/10/2018

Proposed Timescale: 01/08/2018