Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Camphill Jerpoint
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	22 October 2021
Centre ID:	OSV-0003624
Fieldwork ID:	MON-0034229

About the designated centre

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

Camphill Jerpoint provides long term residential care to 10 adults, over the age of 18, both male and female with intellectual disability, autism sensory and physical support needs. The centre is made up three detached two-storey houses each accommodating between one and four residents in a farmyard rural setting. Each resident has their own bedroom and other facilities throughout the centre include kitchens, dining rooms, living rooms, laundries and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (including house coordinators and social care assistants) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 22 October 2021	10:30hrs to 20:30hrs	Tanya Brady	Lead
Friday 22 October 2021	11:45hrs to 20:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This centre had last been inspected in August 2021 to inform a decision on the renewal of registration of the centre. As a result of serious concerns found in relation to fire safety, both immediate and urgent actions were given to the provider regarding fire safety precautions and arrangements in place in the centre. In addition, inspectors found non compliance in other regulations including the governance and management of the centre and risk management procedures. As an outcome of that inspection the Chief Inspector of Social Services held a formal warning meeting and issued a warning letter to Camphill Communities of Ireland on 15 September 2021. The provider was requested to address the issues identified within a specified time frame. Furthermore the relevant County Chief Fire Officer also expressed concerns regarding this centre to the Chief Inspector of Social Services regarding fire safety.

This inspection was completed by two inspectors, one from the fire and estates inspectorate to review progress/regress against the action plan that had been submitted by the provider following the last inspection and against the requested actions as outlined in the formal warning letter. Inspectors adhered to infection prevention and control best practice at all times over the course of the day.

This centre is registered for a maximum of ten residents and currently is home to only nine individuals not all of whom were present on the day of inspection. Inspectors met with a number of residents over the course of the day however, as this inspection was risk based and focused on the regulations contained in the warning letter, time was spent in the premises while residents were out so as to ensure they were not interrupted over the course of their day as much as possible. Inspectors observed that the residents who were present were occupied and supported to go out on activities or engage in tasks around the centre over the course of the day.

This centre comprises two large houses and a single apartment located above day service rooms. All three areas were visited and every room reviewed by inspectors over the inspection day.

Capacity and capability

Since the previous inspection, at the request of the Chief Inspector, the registered provider arranged for a fire safety assessment of the designated centre. The findings of this inspection are that significant progress had been made with a

requisite programme of work, however further risks were identified that required action by the registered provider. These are detailed in the Quality and Safety section of this report.

Overall the inspectors found that the registered provider had demonstrated some improvements in the provision of safe and quality care required for residents in this centre. Although improvements in a number of areas are still required, in particular relating to fire safety, the provider had an identified scheme of work that they were following.

The management team demonstrated awareness of areas that were priorities for improvement and had demonstrated a focus on improved staff consistency and the management of residents personal possessions in particular. The person in charge who was new at the time of the August 2021 inspection was supported by the person participating in management of the centre. They had introduced and initiated many of the providers systems of auditing, oversight and accountability in order to ensure that residents' safety needs were met. It was found that the local management team were driving required changes and improvements.

Regulation 15: Staffing

It had been identified on the last inspection that this centre was without a third of its staffing complement, with agency staff covering the shortfall on rosters. While use of agency staff continues to be high the provider has proactively engaged in a recruitment campaign and the inspectors saw evidence of newly recruited staff ready to begin induction and offers of employment that had been made. These would fill all current vacancies if accepted. In addition the provider and person in charge had removed use of agency staff in one of the premises to ensure better consistency of staffing support and this allowed for the assigning of set staff to the other houses thus improving consistency of support for all residents.

The provider had identified that they also needed to ensure that they could retain staff and had put in place new systems of support and increased training and access to opportunities for current staff. Additionally all agency staff that supported residents in this centre now completed the same training as the staff team and were included in courses to ensure their knowledge of systems they would be required to use was current. These were initiatives that had been positively received within the centre.

While the centre remains with a staffing deficit and high use of agency staff the inspectors found improved consistency of staffing for residents in all three premises.

Judgment: Substantially compliant

Regulation 23: Governance and management

The local management team present in this centre had been consistent since the previous inspection, thereby ensuring that lines of authority and accountability were in place. The regional manager who was the person participating in management for the centre was present at least weekly and ensured they visited all areas of the centre and met with all residents and staff on an ongoing basis.

The provider and person in charge was found to be completing a range of audits that were identifying areas for improvement and these were prioritised and being worked on as part of a clear community action improvement plan. The inspectors found that the progress of these actions were reviewed on an ongoing basis with review dates set and an individual responsible also identified. Where actions remained outstanding such as premises and fire safety these were as a result of substantive resource requirements.

Judgment: Substantially compliant

Quality and safety

The registered provider continues to strive to ensure that residents were in receipt of a good quality and safe service. The residents who met with inspectors were active and engaged in their homes and reported they were happy living in the centre. Inspectors reviewed the key regulations that had been found to be non compliant in the previous inspection and that impacted on the safety of residents.

Overall, the provider had begun to address the overarching and more serious breaches in quality and safety found on the last inspection and clear action plans were found to be in place. Once these actions are implemented in particular in relation to fire safety, there will be a move towards compliance with the regulations.

There was ongoing fire safety works in the centre with good progress on the implementation of the recommendations in the fire safety assessment.

Improvements in fire safety since the previous inspection included:

- Most attics were now cleared of storage
- The programme of work to upgrade fire doors was nearing completion
- Most attic hatches had been replaced with fire rated equivalents
- Most timber sheeted ceilings had been treated with specialist paint to prevent the surface spread of flame
- A fire door had been provided to a kitchen where previously there was none
- The external fire escape stairway had been cleared of the obstruction

- The provider had ensured that all staff had received refresher fire safety training (fire marshall training) as provided by an appropriately qualified external organisation
- All escape routes were now clear of clutter and obstruction
- Acoustic hold open devices had been fitted to fire doors to avoid doors being propped open.

Notwithstanding the above, further fire safety risks were identified during this inspection. These are set out in greater detail under regulation 28.

Regulation 12: Personal possessions

Inspectors found in August 2021 that the providers systems for supporting residents in the management of and safeguarding of their finances were not being consistently and comprehensively implemented.

On this inspection the inspectors found that the provider and person in charge had ensured all staff could access and utilise the systems in place. The inspectors reviewed daily reconciliations and actual amounts of money in wallets and found that they tallied. On speaking with a sample of staff the inspectors were assured that they were familiar with the financial recording processes in place.

Additionally inspectors reviewed the amounts that were paid by residents as outlined in their contracts and found that the standing orders for all residents had been amended and contributions paid were now accurate as per the contract. For the seven residents who had been found to have been overpaying the provider had ensured that all had been reimbursed in full.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had risk management policies and procedures in place in the centre. There was a risk register that had been reviewed since the inspection in August 2021 with evidence that new risks had been identified and added while others had been reviewed and amended or removed as required.

The inspectors found however, that there were some actual risks in the centre that had not been identified and required assessment. These included a staircase in one apartment that presented with a potential risk of falling when using it.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the significant progress implemented in relation to fire safety since the previous inspection, improvements were required in the fire safety management systems in place and further risks were identified on this inspection that required action by the registered provider.

The registered provider was not taking adequate precautions against the risk of fire:

- Inspectors noted an aerosol container on an upper shelf in close proximity to a light bulb in a cleaners store.
- Storage noted beneath an escape stairs was not within a fire rated enclosure.
- A fuse board was found with laundry stored up against it
- An attic space was found with significant storage, however there was a plan to have this removed the following week.
- There was inadequate lighting to some escape routes.

Inspectors were not assured that adequate means of escape was provided throughout the centre. For example:

- A self contained living space for one resident within a house had a room that was considered an 'inner room' and was without appropriate lighting. The resident had to traverse the room to reach a lamp in order to have light, and had to pass through a kitchen and use a stairs in order to evacuate.
- The escape corridor from a resident's bedroom was open to an upper floor craft room
- The head height of some escape routes was lower than would be expected along an escape route and this was not risk assessed.
- The force of closing mechanisms to some fire doors required adjustment to ensure they would not cause injury when released.
  The configuration of the escape stairs, boot room and escape corridor requires review to ensure adequate means of escape.
- Further review of the external escape route from an upper floor apartment was required to ensure it was suitable for the resident living there.
- The thumb turn fastening was on the wrong side of a bedroom door
- The escape stairs from an upper floor bedroom required emergency lighting

Inspectors were not assured that adequate arrangements were in place for giving warning of fire:

- There was a zoned fire alarm system in each building in the designated centre, each comprising numerous zones. The alarm panel will only display the zone where the detector was activated, with staff relying on floor plans to determine the location of the fire. Inspectors noted that the annotation on the floor plans did not match the known use or room number of some rooms and fire zones were not shown. This may lead to delays locating the zone where the fire detector activation occurs. Furthermore, alterations made to

the layout of the building in some instances meant that zones were subdivided, making it difficult for staff to search a zone for a fire.

Adequate arrangements had not been made for containing fires:

- Inspectors were not assured that there was adequate containment of fire to the underside of some flights of stairs, resulting in the escape route not being adequately separated from adjacent risk rooms with fire resistant construction.
- Assurance was required in relation to the fire containment strategy for the dormer attic spaces. For example, inspectors noted inadequate containment between a bedroom and the laundry below.
- Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). There were outstanding upgrade works to some fire doors in Jerpoint House, which were due to be complete the following week.
- Assurance was required regarding the integrity of the fire rated ceilings in some areas where recessed lighting or mechanical extract vents were located in the ceiling.
- Inspectors noted a number of gaps or holes within fire barriers which required sealing to maintain the integrity of the fire rated construction.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Camphill Jerpoint OSV-0003624

Inspection ID: MON-0034229

Date of inspection: 22/10/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A further four whole time equivalent staff have been successfully onboarded. The Community is working with our HR department to recruit and allocate staff according to our whole time equivalent. All staff recruited via agency are receiving training and supervision as per CCoI policy. • Staffing within the community is reviewed weekly with the House Coordinators, • Q & S and PIC to ensure adequate staff are utilized in accordance with the needs of the residents	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • All identified maintenance requirements are escalated to the properties and maintenance department. These actions are scheduled for completion in line with completion dates as per schedule of works.	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • A review of the Centres's Risk assessments was completed by the PIC, Regional Manager and Health & Safety Lead. • A Risk Assessment has been completed to address the hazard associated with the stairs in the building identified on the day of inspection.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Following the latest inspection by HIQA, further work has been undertaken within the community to ensure effective fire safety management as detailed below. • Inspectors noted an aerosol container on an upper shelf in close proximity to a light bulb in a cleaners store. o This item has removed, a sealed light unit has been fitted to the cleaners store and staff advise on appropriate storage for flammable items. • Storage noted beneath an escape stairs was not within a fire rated enclosure. o All escapes stairs have been ungraded with fire-lined plasterboard as specified by our fire engineers. A certificate of compliance is awaited. • A fuse board was found with laundry stored up against it o Items have been removed and staff advised to keep this area free of laundry and other combustible materials. • An attic space was found with significant storage, however there was a plan to have this removed the following week. o All items have been removed and the attic space/void has been closed up and is no longer in use. • There was inadequate lighting to some escape routes. o All escape route lighting has been reviewed and upgraded as per fire engineers report. Certificate of compliance awaited. Inspectors were not assured that adequate means of escape was provided throughout the centre. For example: • A self contained living space for one resident within a house had a room that was considered an 'inner room' and was without appropriate lighting. The resident had to traverse the room to reach a lamp in order to have light, and had to pass through a kitchen and use a stairs in order to evacuate. o The door to the 'inner room' has been removed and appropriate lighting has been installed. Our fire engineer has reviewed the kitchen which is not a functioning kitchen	

and not considered a special risk as no cooking facilities are present. A letter of opinion is awaited from the fire engineer in this regard.

• The escape corridor from a resident's bedroom was open to an upper floor craft room
o The area was reviewed with the fire engineer who is satisfied that the area can be used as a craft room, there are no electrical appliances in this room. A letter of opinion is awaited from the fire engineer in this regard.

• The head height of some escape routes was lower than would be expected along an escape route and this was not risk assessed.
o Fire engineer reviewed and is satisfied that the escape route is adequate, and the existing residents in these areas are able to escape in the event of an alarm activation. Should the residents' circumstances or assessed needs change this will be reviewed, and any changes acted upon appropriately.

• The force of closing mechanisms to some fire doors required adjustment to ensure they would not cause injury when released.
o All door closing mechanisms have been reviewed and the necessary remedial action undertaken to mitigate the risk of injury when released.

• The configuration of the escape stairs, boot room and escape corridor require review to ensure adequate means of escape.
o These areas were reviewed by the fire engineer, clutter in the areas was removed and the area is to be kept clear of items to ensure adequate and unhindered means of escape.

• Further review of the external escape route from an upper floor apartment was required to ensure it was suitable for the resident living there.
o The fire engineer reviewed this area and remedial action was taken in the form of additional fire protections internally to bring the window cill level up to 1100mm and provide protection to occupant in the event of a fire whilst escaping the building.
o
• The thumb turn fastening was on the wrong side of a bedroom door
o This has been rectified and all other doors reviewed.

• The escape stairs from an upper floor bedroom required emergency lighting
o This has now been provided and all emergency lighting throughout the community has been reviewed and upgraded as per fire engineers report. A certificate of compliance is awaited.
Inspectors were not assured that adequate arrangements were in place for giving warning of fire:
• There was a zoned fire alarm system in each building in the designated centre, each comprising numerous zones. The alarm panel will only display the zone where the detector was activated, with staff relying on floor plans to determine the location of the fire. Inspectors noted that the annotation on the floor plans did not match the known use or room number of some rooms and fire zones were not shown. This may lead to delays locating the zone where the fire detector activation occurs. Furthermore, alterations made to the layout of the building in some instances meant that zones were subdivided,

making it difficult for staff to search a zone for a fire.
o Fire alarm zoning and panels have been altered and upgraded. The new zoned layout is provided and currently being drawn up on floor plan by our architect and will be positioned next to be fire alarm panel. A written zone plan is currently in place.
Adequate arrangements had not been made for containing fires:
• Inspectors were not assured that there was adequate containment of fire to the underside of some flights of stairs, resulting in the escape route not being adequately separated from adjacent risk rooms with fire resistant construction.
o All escape routes have undergone passive fire protection upgrades as recommended by the fire engineer. This includes fire lined plaster boarding to the underside of stairs were required. A certificate of compliance is awaited.

• Assurance was required in relation to the fire containment strategy for the dormer attic spaces. For example, inspectors noted inadequate containment between a bedroom and the laundry below.
o All attic voids were assessed by the fire engineer and adequate passive fire protection was put in place to reduce the spread of fire from one area to another. The fire engineer reviewed the construction of the laundry ceiling and deemed this to be appropriate for fire containment (fire lined plaster slabbed ceiling).

• Inspectors were not assured of the likely fire performance of all door sets (door leaf, frame, brush seals, intumescent strips, hinges, closers and ironmongery). There were outstanding upgrade works to some fire doors in Jerpoint House, which were due to be complete the following week.
o All fire door upgrades have now been completed. Certificate of compliance awaited from fire engineer regarding same.

• Assurance was required regarding the integrity of the fire rated ceilings in some areas where recessed lighting or mechanical extract vents were located in the ceiling.
o All recessed lighting was reviewed and replaced with surface mounted ware. Recessed spotlights were upgraded to fire rating lighting as specified by the fire engineer. Certificate of compliance awaited.

• Inspectors noted a number of gaps or holes within fire barriers which required sealing to maintain the integrity of the fire rated construction.
o All gaps and holes have now been sealed with intumescent sealant. Certificate of compliance awaited.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall 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.	Substantially Compliant	Yellow	31/01/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Substantially Compliant	Yellow	31/01/2022

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	23/10/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	30/11/2021
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	30/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment,	Substantially Compliant	Yellow	30/11/2021

	means of escape, building fabric and building services.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2021
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	30/11/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	30/11/2021