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Greenville House, OSV-0002113, 22 November 2021

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

Issued by the Chief Inspector

Name of designated centre:	Greenville House
Name of provider:	Praxis Care
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	22 November 2021
Centre ID:	OSV-0002113
Fieldwork ID:	MON-0034872

About the designated centre

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

The centre provides residential care specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque environment and there is also a day service and other facilities, such as horticulture and outdoor gym equipment in the grounds. The centre comprises a main house and six cottages and can accommodate 13 residents. The main house can accommodate five residents and the bungalows can accommodate either one or two residents. Residents were supported on a 24/7 basis by support workers, team leaders and a social care leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Monday 22 November 2021	08:30hrs to 15:00hrs	Laura O'Sullivan	Lead
Monday 22 November 2021	08:30hrs to 15:00hrs	Elaine McKeown	Support

What residents told us and what inspectors observed

This was an unannounced risk inspection of Greenville completed following receipt of unsolicited information. The centre had previously been inspected under the governance of Praxis care in June 2021 where a high level of compliance was evidenced. The inspectors were greeted at the front door of the main house of the centre on their arrival by a member of the staff team. The inspector's presented their identification prior entering the centre. Upon entering the inspectors were not requested to complete visitors book or to complete COVID 19 checklist. Whilst the staff contacted the person in charge and social care leader inspectors waited in the living room. Residents were yet to rise from bed at this time.

Inspectors were provided with an area to complete the documentation review in a communal activity room. On arrival it was noted that the double entry doors of this room were not fire safety standard and would not provide effective containment in the event of a fire. Also, in this area it was noted that the fire door leading to the utility room was damaged and therefore ineffective. This door also had hand press code access system would be difficult to use in an emergency situation. The provider implemented steps to address this during the inspection.

Following completion of documentary review the inspectors took time to visit and meet with some of the residents currently residing in the centre. The inspectors first visited the main house where five residents currently live. One inspector spent time in the sun room with one resident who was relaxing and keeping an eye on the maintenance work being completed on-site. They questioned the staff on the work being carried out and staff assured them they would return soon with a response. The resident chose not to interact with the inspector but did allow them to look at a number of certs that they had achieved including cookery and art. The resident joined their peers in the kitchen area for lunch. They chose to eat their meal privately and this was facilitated by the staff team. The mealtime was observed to interactive and an opportunity for people to chat and catch up.

The inspectors also visited a resident living in a private apartment linked to the main house. They were being supported by their support staff to prepare the lunch. They washed their hands and were preparing a chicken dinner. The resident showed the inspector their bedroom and said they loved their bed. They showed their DVD's and had a large selection to choose from. The resident appeared very relaxed in their environment, smiling and singing whilst inspectors were present.

One inspector met with two residents in their home in the afternoon while they were relaxing after their lunch. The staff present informed the inspector that one of the residents had returned to the designated centre earlier that morning after spending some time with family representatives over the weekend. During this time they had celebrated their birthday with their relatives. The resident smiled when staff were explaining this to the inspector. The staff outlined the plans for the afternoon activities and was observed to include the resident in the conversation. The plans

included taking the resident out for a drive to a beach as it was a lovely bright afternoon and then to a drive thru restaurant as per the resident's preference and in line with the current public health guidelines. The resident appeared to be relaxed while sitting on the couch in their sitting room. The other resident came out of their bedroom to take some prescribed medication from staff while the inspector was in the house. The staff outlined how this resident enjoyed participating in many different activities in the nearby horticultural tunnel which included using the wheelbarrow. The resident used the wheelbarrow to assist staff to deliver produce from the tunnel to the houses in the designated centre. While the residents were consistently included by staff in the conversations with the inspector both residents chose to only acknowledge the inspector as the inspector left the house. The staff supporting were very familiar with the individual preferences of both residents and outlined how each was supported to participate in individual activities regularly during their day.

The other inspector visited another two residents in their cottage, they had also returned from spending time with family over the weekend. One resident was in the kitchen area with staff and were preparing the vegetables for lunch. One resident had chosen soup for lunch which was being freshly prepared. Another was having pasta and salad. One resident was utilising his communication aid to communicate with staff the activity he had chosen for the afternoon. They were going for a spin and calling to the MacDonald's drive through for a cup of coffee. Staff reported that the other resident preferred to complete activities in the centre rather than going out an about. Staff present was keenly aware of the needs of the residents present and to the needs of the service within Greenville.

Each area visited displayed individual preferences with homely atmospheres evident in all areas. One house had a small tent set up in a room with a mattress. Staff explained that a resident liked to hide and had a blanket which they liked to have placed on top of themselves which they found very comforting. Another resident was observed to engage with staff to prepare lunch for themselves, other peers and staff on duty in the house. Residents in two other houses were out in the community with staff when the inspectors called to their houses.

It was evident during the inspection that staff spoken to were very familiar with individual residents' routines and preferences. One staff advised in advance of meeting a resident that the person may ask a lot of personal questions. They advised the inspectors how to respond if they were not happy to answer any of the questions in advance of meeting the resident. Another staff member was observed to spontaneously join in signing a song with a resident they were supporting at which the resident smiled. Staff also spoke of how the team assisted each other and new staff when required. For example, if staff needed assistance accessing the provider's internal computer system such as incident reporting or completing required documentation as per the provider's protocols.

Overall, Greenville presented as a good service which residents reported they were happy with. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the

service being delivered.

Capacity and capability

The registered provider had ensured the appointment of a clear governance structure to maintain oversight in the designated centre. This included the allocation of a suitably qualified and experience person in charge to the centre. They had a keen awareness of their regulatory responsibilities and to the supports needs of the residents. The person in charge had delegated a number of duties to the allocated social care leader with clear roles and responsibilities in place. The person in charge and social care leader reported to the person participating in management.

The registered provider had ensured the implementation of the regulatory required monitoring systems since the previous inspection the six monthly unannounced visit to the centre in August 2021. These were comprehensive in nature and did incorporate consultation with residents. The person in charge and social care leader also completed a number of monitoring systems within the centre. This included medication audits, Infection control audits and daily fire checks. These were evidenced to be beneficial to identify areas requiring address and to ensure identification of all areas of non-compliance and drive service improvements.

The registered provider had ensured that the number, qualifications and skill mix of staff was appropriate to the assessed needs of residents. The person in charge outlined how the social model of care supported residents in each house as per each resident's individual assessed needs. The person in charge had ensured there was an actual and planned rota in place. The rota was flexible to meet the assessed needs of individual residents with a core staff team providing support to ensure consistency of service provision to residents. Shift patterns in each house reflected the assessed needs of the residents living in the houses. For example, some shifts started in the afternoons when residents were supported to go out on community activities as per their preference, other residents did not require a waking staff at night but staff were available in an adjacent house should the resident require assistance during the night Staff were supported to transition to the core staff team through an induction system and a probationary period.

The person in charge and the social care leader ensured staff were appropriately supervised. A number of team leaders were also appointed to the centre to ensure a governance oversight was in place for the day to day operations of the centre. Staff spoken with expressed that a concern can be raised and that this is rectified as required. Formal supervisory meetings were completed in accordance with an organisational policy. Upon review of a number of these it was noted these were utilised as an opportunity to raise concerns and address any outstanding issues. One recurring agenda item was that of staff training.

The person in charge had a detailed training matrix which included the outstanding training requirements of staff. The inspectors were informed that there was

scheduled fire safety training for all staff in the days following this inspection. However, not all staff training was up-to-date at the time of the inspection, this included safeguarding 17%, managing behaviours that challenge 38%, and medication management 13% and fire safety 72%

There were no open complaints in the designated centre. No new complaints since the last inspection in May 2021. Residents representatives and staff were aware of the complaints procedure. The provider had a comprehensive complaints policy which included an appeals process, an easy-to-read raising a concern flowchart and monthly monitoring by the head of operations.

Regulation 14: Persons in charge

The registered provider had ensured the appointment of a suitably qualified and experienced Person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The person in charge had ensured there was an actual and planned rota in place. The rota was flexible to meet the assessed needs of individual residents with a core staff team providing support to ensure consistency of service provision to residents.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had a detailed training matrix which included the outstanding training requirements of staff. The inspectors were informed that there was scheduled fire safety training for all staff in the days following this inspection. However, not all staff training was up-to-date at the time of the inspection, this included safeguarding 17%, managing behaviours that challenge 38%, medication management 13% and fire safety 72%

Judgment: Substantially compliant

Regulation 23: Governance and management

Through a clear governance structure and implementation of a range of monitoring systems the service provided in Greenville was evidenced to be safe and effective in nature. It was resourced to ensure effective delivery of care and support in accordance with the statement of purpose.

Effective measures were in place to support the staff team to raise concerns with respect to the quality and safety of care and support provided to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had ensured the statement of purpose was subject to regular review. It reflected the services and facilities provided at the centre and contained all the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured the notification of all required incidents.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints in the designated centre. No new complaints since the last inpsection in May 2021. Residents representatives and staff were aware of the complaints procedure. The provider had a comprehensive complaints policy which included an appeals process, an easy –to-read raising a concern flowchart and monthly monitoring by the head of operations.

Judgment: Compliant

Quality and safety

As stated previously this inspection of Greenville was undertaken following receipt of unsolicited information, therefore, only a specific number of regulations were reviewed. Overall, from documentation provided and observations on the day it was evidenced that the service provided in Greenville was safe in a nature. Residents were supported to engage in a range of activities of their choice and their dignity and privacy was respected by a familiar and consistent staff team. Residents were also supported to have access to advocacy services if required. Residents were supported to engage in regular meetings with staff in their homes. Some meetings were done in group settings others on an individual basis, depending on each resident's preferences. The provider had developed a resident meeting template which included rolling topics such as safeguarding, human rights, complaints and healthy eating. In addition, regular staff team meetings in the houses ensured all staff were familiar with any changes or supports required for the residents to whom they were providing support, such as ensuring consistent approaches to dental care and the management/laundering of personal clothing for individual residents.

The registered provider had effective systems in place to ensure all residents were protected from abuse. This included the development and adherence to an organisational policy and staff training. Staff spoken with were aware of whom to speak with if they had a concern. Where a concern did arise, there was evidence of effective review of the incident and implementation of measures to ensure the safety of all residents was paramount. Where needed, additional advice was sought from external agencies and through the organisational governance structure on measures required to ensure residents were safe at all times. Safeguarding plans were in place as needed, to ensure all staff had an awareness of concerns and were consistent in their approach to supports.

While the provider had a policy in place regarding the management of residents finances, not all documentation was completed as per the provider's protocols. For example, some residents' personal finances check sheet were not completed at the start of every shift as required and were not always signed by two staff. For example, no record of a resident's money being checked at the start of shifts was documented on 19 and 20 November 2021. The provider also required each calendar month had a check sheet but this was not evident in two residents' personal finances documentation. One resident had dates for both October and November on one sheet. Receipts were also not kept separate for each month as required. For example receipts for three months were stored together for one resident. In addition, financial forms from a previous provider of services in the designated centre were found in both residents financial documentation.

Residents were supported to engage in regular meetings with staff in their homes. Some meetings were done in group settings others on an individual basis, depending on each resident's preferences. The provider had developed a resident meeting template which included rolling topics such as safeguarding, human rights, complaints and healthy eating. In addition, regular staff team meetings in the houses ensured all staff were familiar with any changes or supports required for the residents to whom they were providing support, such as ensuring consistent approaches to dental care and the management/laundering of personal clothing for

individual residents.

Whilst completing a walk around of the centre it was noted that a number of fire doors were ineffective. One damaged fire door also had a coded access system which may be difficult to access in the event of an emergency. This was highlighted to the governance team who commenced actions to address this immediately during the inspection.

Regulation 12: Personal possessions

Whilst a policy had been developed in area of resident finances improvements were required with respect to adherence to this. For example, double signing of all receipt transactions. Also, due to non adherence to policy staff spoke of inconsistencies in the logging of financial transaction. It was noted that all balances of finances reviewed on the day of inspection were present and accurate.

Judgment: Substantially compliant

Regulation 28: Fire precautions

It was noted on the day of inspection that a number of doors required attention. One door accessing a utility room was damaged and the coded access system could cause difficulty in an emergency. Double doors accessing a communal activity room were not fire standard doors and required review.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had effective systems in place to ensure all residents were protected from abuse. This included the development and adherence to an organisational policy and staff training.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to engage in activities of their choice and their dignity and privacy was respected by a familiar staff team. Residents were also supported to have access to advocacy services if required.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Greenville House OSV-0002113

Inspection ID: MON-0034872

Date of inspection: 22/11/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge will ensure that all staff have completed Mandatory training; to include Safeguarding, Managing Behaviours which Challenge, Medication Management and Fire Safety. Date: 24.12.21 • The Provider will ensure Training matrix is reviewed monthly as part of Monthly Monitoring and reported on. Date: 17.12.21 • The PIC will plan for all trainings to be completed in advance of renewal dates. Date: 17.12.21	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • The Provider will ensure that all finance records are used in line with Praxis Care Policy. Date: 21.12.21 • The Provider will ensure Finance folders are reviewed as part of monthly monitoring visit by the Head of Operations. Date: 21.12.21 • The PIC has made available Finance folders in each which contain Praxis Care finance management policy as well as all templates for accurate reporting in line with policy. Date: 21.12.21 • The PIC has ensured all staff have been made aware of the policy and required documentation. Date: 21.12.21 • The PIC will ensure monthly audits of SU finances are carried out.	

Date: 21.12.21	
Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Provider has ensured the key pad entry has been removed from utility door.
Date: 17.12.21
• The Provider will ensure Fire Doors are replaced and meet required standards in the event of a fire.
Date: 7.01.21

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	21/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	24/12/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Substantially Compliant	Yellow	07/01/2021

	containing and extinguishing fires.			