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:	Grange Bective
Name of provider:	Praxis Care
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	19 November 2019
Centre ID:	OSV-0001913
Fieldwork ID:	MON-0027692

About the designated centre

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

Grange Bective is a full time residential service that can provide appropriate quality care and support to individuals experiencing mental ill health, learning disability, Autism, dementia or brain injury. Grange Bective can accommodate five residents, both male and female over the age of 18 years. The centre consists of a two storey, dormer style bungalow, situated outside a large town in County Meath. Each resident has their own bedroom which had been decorated to the residents taste and choice. The centre includes an independent living unit which accommodates one resident and is connected to the remainder of the house via a hallway and connecting door. Residents are supported 24 hours a day, 7 days a week by a person in charge, team leaders, and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
19 November 2019	09:00hrs to 18:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

On the day of inspection, four of the five residents were in their home. The inspector had the opportunity to briefly speak with one resident and observe the other three residents during different parts of the day. Not all residents used verbal means to communicate, some residents used alternative methods to communicate such as gestures, and facial expressions. The inspector was supported to interact with the residents appropriate to their assessed needs.

Residents' spoken with, relied on prompting from staff to respond to the inspector. With these prompts a resident was able to tell the inspector about the goals they were working on and what the resident had achieved in relation to these goals. They spoke about the importance of family connections, and of items they liked to collect and the type of music they enjoyed. During observations the resident was comfortable in staff presence and readily requested staff assistance when needed.

Observations across the day indicated that residents were treated respectfully and interactions from staff were kind and patient in nature. Staff were very knowledgeable around residents specific needs and respectful of their individual choices. Staff were observed to use communication aids in line with the residents' assessed needs, for example using objects of reference and pictures to aid residents comprehension of different routines.

Residents appeared happy and were observed to smile at staff members and respond to instructions and prompting provided accordingly. Staff spoken with understood their role in supporting residents and were striving to provide a quality and safe service in line with each residents specific needs.

Capacity and capability

The inspector found that the registered provider and the person in charge had effective management arrangements in place to ensure a quality driven, safe service was provided to residents. Changes had recently occurred in the staff team, supervision of staff and in the systems for oversight of the service. These were discussed in detail on the day of inspection. The impact of these changes were ensuring continuous quality improvement in the service. Due to the effective governance in the centre there were positive outcomes for residents, where each residents' specific needs were considered. Overall good levels of compliance were found across the regulations inspected against.

The provider had ensured that there were clear management arrangements to ensure appropriate leadership and governance. There were team leaders

permanently based in the centre with support from a person in charge. The team leaders worked a variety of shifts, including a sleep over shifts seven days a week. Direct care workers reported to the team leaders who were directly supported by the person in charge. The person in charge directly reported into the Head of Operations. Staff were aware of their individual responsibilities and the relevant reporting structures.

There were appropriate systems and processes in place that underpinned the safe delivery and oversight of the service. There was an annual review of quality and safety of care of residents in the service that had been completed in February 2019. Residents contribution to this report was noted through observations. Families were also given the opportunity to contribute their views and thoughts about the quality and care provided. Two unannounced visits were completed in 2019. Additional to the above the provider also required that monthly monitoring visits were completed, and two self assessment judgement frameworks in line with regulation were also completed. These comprehensive assessments of the quality and care in the service were readily identifying areas of improvement. Actions from these reports were put in a Quality Improvement Plan (QIP) and reviewed on a weekly basis by the person in charge. Oversight of QIP also occurred regularly from the Head of Operations and Director of Care. Actions identified were being completed in a timely manner. For example the self assessment judgement framework completed in September 2019 had identified approximately 53 actions, only 13 outstanding actions remained on the day of inspection and these were in the process of being completed. This comprehensive system of oversight of service delivery was enabling self-identification of any problems or barriers to service provision and putting in effective plans for relevant improvements. This was impacting positively on residents' quality of care.

On the day of inspection, there were 4.5 whole time equivalent vacancies across the staff team. Recruitment for these posts had been advertised and interviews were being held over the coming weeks. In order to ensure continuity of staff and safe delivery of care, a panel of regular relief staff were being utilised. Overall, the staff team in place were found to have the right skills, qualifications and experience to meet the assessed needs of residents.

The staff training needs and development was organised and managed in a way to ensure that they had the required skills, experience and competencies to respond to the individual needs of the residents. All staff had received training in areas specific to providing evidence-based, quality and safe care. Staff had completed training in areas such as safeguarding, fire safety, safe administration of medication, behaviour support and de-escalation techniques to name but a few. The provider had also arranged and was in the process of arranging additional training to further compliment the staff teams level of expertise, for example training in specific areas of communication.

There had been some staff changes over the recent months, the provider recognised their role in ensuring that continuity of staffing and promoting the organisations' culture and ethos could be further strengthened by adapting the supervision process with staff. Specific one to one supervision sessions

were completed with all staff and the Director of Operations. Specific topics such as staff members understanding of roles and responsibilities, understanding of staffs responsibility of Health Act 2007, understanding of restrictive practices, understanding of safeguarding, and best practice in relation to specific residents and training needs. This tailored supervision was ensuring a positive working environment was promoted. In addition to this, supervision was occurring minimally ever 2 months with either the person in charge or the team leader. Notes reviewed indicated that a wide range of topics were discussed in relation to staffs individual roles. Staff spoken with described the level of support received and that they felt both formal and informal supervision was essential in helping them complete their roles effectively.

Regulation 15: Staffing

Staff had the right skills, qualifications and experience to meet the assessed needs of residents, however, there were staff vacancies totalling 4.5 whole time equivalents across the staff team on the day of inspection. Recruitment for these posts was occurring and interviews were scheduled over the coming weeks.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date, evidence based practice. Supervision in place was tailored to ensure it improved practice and accountability.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were in place to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. A nominated person from the organisation visits the centre at least once every six months and produces a report on the safety and quality of care and support provided in the centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

A written contract for the provision of services is agreed on admission and had been signed by the resident and/or their relevant representative.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints process was in an accessible format to the residents and was displayed prominently. There was a suitable nominated person to deal with all complaints and they ensured all complaints are recorded and fully and promptly investigated.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents received a person centred model of care and that they were supported to experience a good quality of life. Residents took part in activities that were meaningful to their lives. Staff were very knowledgeable about each resident's preferences, needs and communication style.The inspector found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was person centred and suitable for the assessed needs of the residents. Residents were provided with supports in line with their assessed needs. The good quality level of service provision resulted in overall good levels of compliance with regulations.

The inspector completed a walk around of the centre and found that it was warm, clean, homely and decorated to each resident's individual preferences. For example some bedrooms were minimally decorated in line with residents' wishes, where as other residents' bedrooms were decorated with posters, pictures and collectable items in line with their preferences and tastes. There was adequate communal and private space for all residents. The layout of the centre was adapted to meet the residents' needs, with one self-contained apartment in the centre adjoining the main house, to facilitate an independent living space. There was a large outside area with suitable recreational items to facilitate residents' sensory needs. Residents also had access to a sensory room on site. Any minor maintenance improvements hand been identified by the provider and were in the process of being completed.

The communication style and ability of each resident varied, some residents used

verbal language to communicate and other residents used gestures, facial expressions, and body position to indicate items they wanted or needed. Objects of reference and pictures were used to facilitate residents understanding of different activities that were occurring. Residents' personal plans had communication passports that were used to help staff, and other relevant people understand the residents unique ways of communication. Some residents had availed of supports from the Primary Care Team, in relation to speech and language, and notes from these visits were reviewed by the inspector. Recommendations indicated that the residents were to continue with the relevant supports in place and were discharged from this service. In order to continue to promote best practice in this area the provider was exploring additional means to ensure the residents were assisted to communicate effectively.

A sample of residents' personal plans were reviewed by the inspector. 'Everyday living plans' reflected the assessed needs of the individual residents and outlined the supports required to maximise their development in accordance with their individual health needs, personal needs and choices. A monthly review of the effectiveness of this plan was completed by the key worker with oversight from a team leader and/or person in charge. Multidisciplinary reviews of the plan also occurred on a regular basis and plans were updated to reflect any change in needs. However, social care goals were not always accurately reflected or documented in the residents' personal plan. At times, social care goals were not reviewed on a regular basis. This documentation piece did not pose any medium to high risk to the residents, however, development of the process in capturing, documenting and reviewing social care goals would result in improved quality of care for residents. Additionally, an annual review of the residents' personal plan was completed which evaluated the effectiveness of goals and and made relevant plans and suggestions for the upcoming year. Residents' representatives were afforded the opportunity to contribute to this review, however, residents participation in this process was not always adequately documented and or accounted for.

Appropriate healthcare was provided to each resident in the centre. Healthcare needs were met by allied professionals within the community. Where required healthcare plans were in place to address specific needs and they were found to be sufficiently detailed to guide staff practice. Some residents found healthcare appointment and relevant interventions, such as taking blood samples, stressful. Staff recognised these barriers in relation to residents possibly accessing appropriate healthcare and were using innovative ways to help the residents cope and be less anxious around these situations.

A sample of positive behaviour support plans were reviewed. Residents had access to relevant allied professionals, such as psychiatry, psychology and behaviour support specialists in order to help address any specific needs. Positive behaviour support plans were developed in line with a function based approach to managing behaviours that challenge. Detailed proactive strategies were described, in addition to reactive strategies in line with a 'traffic light' based approach to topographically defined behaviours. This enabled clear guidance to staff on how to address specific needs. Restrictive practices were in place for a number of residents. A clear rationale for their use was in place with associated risk assessments. Restrictive practices

were reviewed on a regular basis and also discussed at the residents' annual review meeting. There was evidence that the provider was in the process of reducing restrictions were possible, for example a door that had been on a key pad lock was now removed, and a less restrictive option had been applied. If a restrictive proactive was in place as a reactive strategy, it was clearly documented in the behaviour support plan to be used as last resort once all other relevant strategies in the plan had been utilised.

Staff had received training in safeguarding and staff spoken with were very knowledgeable in their role in relation to keeping residents safe from abuse. Staff were cognisant of each residents individual ability to keep themselves safe and recognised the importance of staff support in this regard. Accessible information on safeguarding was displayed in the centre. A sample of staff meeting notes were reviewed and the topic of safeguarding was discussed at regular intervals. Although the provider was striving to keep residents safe a number of alleged safeguarding incidents had occurred in the centre over recent months. The provider had a clear rationale to why such incidents occurred which included medication changes and a changes in living arrangements within the centre. Each safeguarding incident was appropriately managed, investigated and reported to relevant agencies. Learning was also identified from each incident which reduced the further occurrence of similar events. The providers response and knowledge around safeguarding provided assurances that residents were safe in their home and they were protected to their best of their ability in relation to any incidents which occurred.

Evidence reviewed by the inspectors showed that the registered provider took a proactive approach to risk management in the centre. Any incident and or accident that occurred in the centre was logged on an online system, reviewed by the person in charge and the Head or Operations. Learning identified was recorded on the accident and incident log and relevant actions were generated. When required, incidents were escalated to the Director of care for further oversight. A sample of risk assessments were reviewed. The risk assessments were updated as required, for example learning identified following an incident in a vehicle, had been appropriately updated in relevant individual risk assessments.

In terms of fire precautions the provider had put in a number of measures to ensure the safety of the residents and staff. There was adequate means of escape with emergency lighting provided. Suitable fire containment measures were in place in the home. There was a procedure for the safe evacuation of residents and staff in the event of a fire which was prominently displayed. Fire drills had been completed at regular intervals. Staff and residents were provided with education and training around fire safety.

Regulation 10: Communication

Individual communication requirements were documented in residents' personal

plans and reflected in practice.

Judgment: Compliant

Regulation 17: Premises

The premises was warm, homely and decorated in line with residents specific needs and wishes. Rooms were of a suitable size and layout suitable for the needs of residents.

Judgment: Compliant

Regulation 26: Risk management procedures

Arrangements were in place for identifying, recording, investigating and learning from incidents and accidents occurring in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced when required. There was adequate means of escape, including emergency lighting. The understanding of the fire evacuation procedure for residents had been adequately accounted for in the evacuation procedure.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan that was kept under review and reflected in practice, but there are some gaps in the documentation piece that did not result in a medium or high risk to residents. For example, residents' social goals and the effectiveness of the plans associated with these goals were not adequately captured in the residents personal plan. In addition to this the evidence in relation to the residents' participation in the review of their plans was not always captured effectively.

Judgment: Substantially compliant

Regulation 6: Health care

Appropriate healthcare was made available for each resident, having regard to that resident's personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans are in place when required. Where restrictive procedures such as physical, chemical or environmental restraint were used, such practices were applied in accordance to national policy and evidence-based practice.

Judgment: Compliant

Regulation 8: Protection

The person in charge has initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse and takes appropriate action. Safeguarding is continually promoted as staff understand their role in adult protection and are able to put appropriate procedures into practice when necessary.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Grange Bective OSV-0001913

Inspection ID: MON-0027692

Date of inspection: 19/11/2019

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.

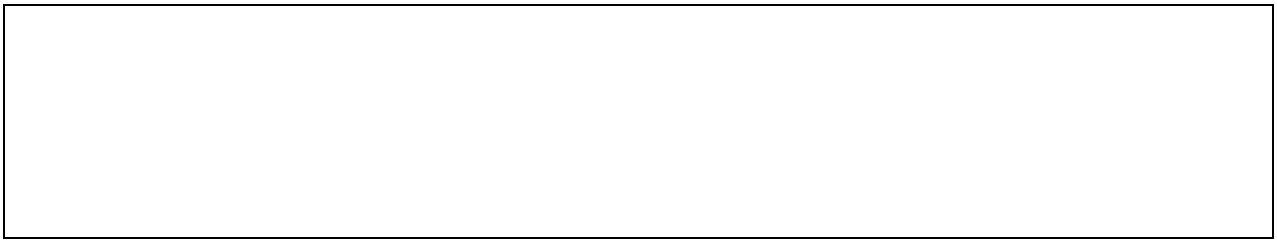
- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents 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: The provider has ensured that recruitment is currently active and interviews for support worker are scheduled for 20th December '19. Further recruitment is planned for January to create a wait list for support workers. Current support worker vacancies will be filled by 28/02/2020. Two team leaders have been recruited and are commencing in post week 16th December '19 and 6th January '20 respectively. A wait list for Team Leaders has been created. The Provider will ensure that all vacancies will be filled by 28/02/2019	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The Provider has ensured that each resident has a comprehensive assessment of their needs completed annually. The provider will ensure that each residents personal plan will be reviewed to ensure social goals are captured by 31/01/2020. Each resident has a key worker and monthly 1:1 key working meetings have commenced from December 2019. A staff meeting occurred in November 2019 to outline staff's responsibilities in supporting residents to achieve social and personal goals. Each resident will participate in determining their personal and social goals in their monthly key working meeting. The Provider will ensure that resident annual reviews ensure maximum participation from residents. Resident's annual reviews will document outcomes achieved throughout year. Resident's participation in annual reviews will be documented and evident through a variation of communication methods. The Provider will ensure that personal plans are updated following an annual review.	



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	28/02/2020
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of	Substantially Compliant	Yellow	31/01/2020

	each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/03/2020