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 Community of Ireland Greenacres
Name of provider:	Camphill Communities of Ireland
Address of centre:	Dublin 14
Type of inspection:	Unannounced
Date of inspection:	02 December 2022
Centre ID:	OSV-0003623
Fieldwork ID:	MON-0038484

About the designated centre

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

Greenacres is a residential home for three adults with an intellectual disability who require low to medium supports. The centre is located in a suburb in South Co. Dublin and is close to a variety of public transport links. There are shopping centres, pubs and local shops within close proximity of the centre. Residents have the opportunity to attend day services or avail of training, employment or volunteer work in their local community. Residents are supported 24 hours a day, seven days a week by social care workers and volunteers. The property has seven bedrooms, a kitchen and dining room, and a sitting room. The property also has a large garden with a seating area and a storage shed, and a detached office at the back of the garden. Each resident has an ensuite bedroom.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 (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 2 December 2022	10:00hrs to 16:30hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

From speaking with residents and staff, and from what the inspector of social services observed and read, significant improvements had been made to the governance and management of the centre since previous inspections. The inspector found that the provider's systems for monitoring care and support for residents were being implemented effectively. Audits and reviews by the provider and the local management team were identifying areas for improvement and leading to improvements in relation to residents care and support and their home. Improvements were found across the majority of regulations reviewed during this inspection.

This unannounced risk based inspection was completed following an increase in the submission of allegations of abuse to the Chief Inspector of Social Service between September 2022 and the date of the inspection. Eleven allegations of abuse had been submitted since the last inspection, and nine of these were submitted between September 2022 and the date of the inspection. Overall the inspector of social services found that efforts were being made to ensure that residents were being supported to enjoy a good quality of life. However, due to the recent trend of allegations of abuse in the centre, further improvements were required to ensure that the registered provider was protecting residents in the centre from abuse. The provider had identified the trend of allegations of abuse and was taking some responsive actions to safeguard residents. However, the inspector found that they were not fully aware of the impact, particularly for one resident, and that the control measures in place were not proving fully effective at the time of the inspection.

There were three residents living in the centre, and the inspector had an opportunity to meet each of them. On arrival, the inspector was directed by staff to the hall table where there was a thermometer, a visitors sign in, hand sanitiser, and personal protective equipment available. As the inspector was signing in a resident arrived home after attending an appointment. They welcomed the inspector and then went to the kitchen to get their breakfast which staff had in the oven for them.

Greenacres is a large six bedroomed house in the suburbs of South Dublin. Each resident has their own bedroom and ensuite bathroom. There are plenty of private and communal spaces, including spaces for residents to meet their family or friends in private. There is a front driveway and a large back garden with seating areas, a social hub, and a shed. A number of improvements were noted to the premises since the last inspection, including painting in a number of areas. Plans were in place for further improvements including works to the garden, the development of a sensory room, and works to the outdoor social hub. Overall, the house was well maintained. Records were maintained of required, and completed works.

The inspector observed the mealtime experience for two residents during the inspection. There was a relaxed atmosphere in the kitchen coming dining room, and residents were choosing what they wished to eat and drink, and when. Residents

were also observed to be involved in the upkeep of their home, including cleaning up after their meal.

Residents were observed to choose the activities they engaged in during the inspection. One resident spoke about getting their flu and COVID-19 vaccine and they said that they were happy to be "all protected for Christmas". Another resident showed the inspector their social hub in the back garden. There was computer and music equipment, including a guitar and an electric drum set. They talked about joining a band and how much they were enjoying this. They showed the inspector their electric drums and headphones and talked about how they liked to play their drums with their headphones on, so they wouldn't disturb anyone with the noise.

There was evidence that residents had increased opportunities to engage in activities outside their home since the last inspection. They were attending day services or taking part in activities in their local community. One resident was a talented artist and had completed a number of art pieces. They were now selling them. Residents were also enjoying activities in their home such as, listening to and playing music, playing cards on their tablet computer, watching videos on their tablet computer, or watching their favourite television programmes.

Kind and caring interactions were observed between residents and staff throughout the inspection. However, the inspector observed one interaction between two residents where one resident appeared uncomfortable and covered their ears when their peer was speaking. They then made their excuses, and left the the room. For the most part residents told the inspector that they were happy and felt safe in their home; however, one resident spoke with the inspector about a number of recent safeguarding concerns in the centre. They described the negative impact of interactions between themselves and one of their peers over the last few months. They said that staff listen to them when they raise their concerns and that staff were trying their best to put plans in place to prevent it happening again, but that they were "sick and tired of it", and "I cant keep worrying about whether they are having a good day or a bad day". They said that staff were putting plans in place, but that these plans were not fixing the problem. They said "staff support my welfare" but "sometimes I don't feel safe".They told the inspector that they felt that sharing their home with their peer wasn't working. They spoke about how they felt that their peer was targeting them and that they did not feel it was right that they had to go to their room or to the social hub when their peer was engaging in certain behaviours.

The inspector acknowledges that the provider had taken a number of steps to attempt to address the incompatibility of residents in the centre. These included, putting forward a business case to the funder, holding emergency review meetings due to an escalation in behaviours of concern in the centre and following this increasing the whole time equivalent (WTE) staff numbers in the centre by 0.5 WTE, supporting residents to develop their knowledge and self-awareness in relation to self-care and protection. In addition, the provider is funding play therapy and psychological services for residents who choose to engage in these services. Despite these efforts and the additional control measures implemented in safeguarding plan, they were not proving fully effective. This will be discussed further under Regulation

8 later in the report

Residents' meetings were occurring regularly and discussions were being held in relation to activities, personal plans, safety and security, abuse, advocacy, events in the community, and the maintenance and upkeep of their home. There was information on display in relation to the confidential recipient, complaints, the residents' guide, and easy-to-read information on abuse. All three residents had, or were, engaged with independent advocacy services.

Resident and their representative's input was sought as part of the provider's annual review of care and support. Feedback from residents and their representatives was mostly positive. They were complimentary towards the staff team and volunteers, particularly how they supported residents in times of illness, and during the pandemic. In the 2021 annual review, a number of residents' representatives referred to the high turnover of staff and the need for more varied activities for residents.

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 the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings of this inspection were that improvements had been made in relation to the governance and management of this designated centre, and in relation to the oversight and monitoring of care and support for residents. However, improvements were required to ensure that residents were safeguarded from abuse. This will be discussed further, later in the report.

The inspection was facilitated by the person in charge and the person participating in the management of the designated centre (PPIM). The person in charge had commenced in their role approximately a year before the inspection. They had systems in place to monitor the quality of care and support for residents. They were based in the centre and available to support residents and staff. In their absence, there was an on call management system. They were found to be familiar with residents' needs and motivated to ensure they were happy, well supported, spending their time as they wished, and achieving their goals. Residents were observed to be familiar with the person in charge, and staff were complimentary towards how they supported them to carry out their roles and responsibilities. The PPIM was visiting the centre regularly and providing the person in charge with support and supervision.

Improvements were found in terms of staffing numbers and continuity of care an support for residents. The provider had recruited a number of staff and the inspector viewed probation and supervision records which demonstrated that they had received a thorough induction to the centre. Overall, there were systems in

place to ensure that staff had the training they needed to support residents in line with their assessed needs.

Staff meetings were occurring regularly and agenda items were residents focused, and varied. Discussions included areas such as, policies, procedures and guidelines, staff training and development, health and safety, maintenance and repairs, rosters, complaints, a review of residents' care and support. The provider and local management team were completing audits and review, including the six monthly unannounced visits and an annual review of care and support. There were trackers in place to merge actions from audits and reviews, and to ensure the required actions were completed.

Regulation 14: Persons in charge

The new person in charge had the qualifications, skills and experience to meet the requirements of Regulation 14. They had commenced in their role in late 2021 and were found to be aware of their roles and responsibilities in relation to the regulations. They were motivated to ensure that residents were happy, and felt safe living in their home. They were also focused on ensuing that the diversity and uniqueness of residents was celebrated and that residents were aware of their rights, and supported to exercise them. They were also found to be aware of the areas where improvements were required to bring about compliance with the regulations and to improve the quality and safety of care and support for residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

From a review of a sample of rosters and discussions with residents and staff, it was evident that there were the right number of staff to meet the number and needs of residents living in the centre. There were no staffing vacancies in the centre at the time of the inspection.

There had been improvements in terms of the continuity of care and support for residents since the last inspection. The provider has plans to further improve this by recruiting a regular relief panel to cover planned and unplanned leave.

Improvements were also noted in relation to the maintenance of planned and actual rosters in the centre.

Residents were very complimentary towards staff in the centre and the inspector found that staff who they spoke with during the inspection were very knowledgeable in relation to residents' wishes and preferences, and motivated to ensure they were

in receipt of person-centred care and supports.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector found that staff in the centre were supported to complete training to support them to provide person-centred services and supports for residents. They had completed mandatory training in line with the organisation's policies and procedures. They had also completed a number of training programmes in line with residents' assessed needs.

Staff were in receipt of formal supervision in line with the provider's policies and procedures, and the new person in charge had a schedule in place to ensure this continued. The agenda items of supervision meetings were varied and discussions included performance management, staff's roles and responsibilities, residents' welfare, supports available to staff, and staff's personal development and training needs. The person in charge was in receipt of regular formal supervision completed by the PPIM. Detailed records were maintained, and there was a clear focus on staff's roles and responsibilities and monitoring and oversight of care and support for residents.

Judgment: Compliant

Regulation 19: Directory of residents

There was a directory of residents in place and it was found to be up-to-date and to contain the information required by the regulations.

Judgment: Compliant

Regulation 21: Records

Records were well maintained and easy to access on the day of the inspection. They were secure but easily retrievable.

Judgment: Compliant

Regulation 22: Insurance

The centre had appropriate insurance in place against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that significant improvement had been made in relation to the governance and management of this centre since previous inspections. The provider and person in charge were completing audits and reviews and identifying areas where improvement were required. They were putting action plans in place to bring about these improvements. There were clear dates for the completion of actions and the person responsible for completing the actions was clearly identified.

Staff meetings were now occurring regularly and there were systems in place to support staff to carry out their roles and responsibilities to the best of your abilities. The person in charge and PPIM were meeting regularly and had effective systems in place for the oversight and monitoring of care and support for residents.

They had identified the trend of allegations of abuse in the centre and were in the process of implementing a number of control measures and completing compatibility assessments at the time of the inspection. These actions needed to progress due to the impact of the alleged abuse for residents living in the centre. This will be discussed further under Regulation 8.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was in place and available in the centre. It was being regularly reviewed and updated in line with the timeframe identified in the regulations and it contained the required information.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the quality of care provided for residents was of a good standard. However, as previously mentioned improvements were required to the safeguarding arrangements in the centre to ensure residents were happy and felt safe in the centre. The provider was aware of this and in the process of completing compatibility assessments for residents at the time of this inspection.

Residents were protected by the risk management policies, procedures and practices in the centre. The provider had developed a policy and there was a risk register in place. General and individual risk assessments were developed and reviewed as required. There were emergency plans in place and systems to ensure incidents were recorded and followed up on. They were also protected by the fire safety measures in the centre. There was suitable fire containment measures in place and systems in place to ensure that fire equipment was in place and serviced regularly. There were adequate means of escape and emergency lighting in place. Residents has personal emergency evacuation plans in place and staff had completed fire safety awareness training.

There was evidence that increased efforts had been made in the centre to demonstrate that residents were being supported to develop their knowledge, self-awareness, understanding and skills needed for self-care and protection. This included key worker sessions and discussions at residents' meetings. There was also information on display for residents in relation to abuse, the availability of independent advocacy services, and the complaints process. In addition, there was evidence of an increased focus for staff on recognising and responding to allegations and suspicions of abuse in line with a trend of allegations of abuse in the centre in the months preceding the inspection.

Residents' assessments and plans were found to be person-centred, and to contain sufficient detail to guide staff in relation to any supports they may require. Their healthcare needs were assessed and care plans were developed and reviewed as required. They had access to allied health professionals in line with their assessed needs. Plans were in place to ensure that each resident had an annual review of their plans.

Allegations and suspicions of abuse were screened and followed up on in line with the organisation's and national policy. Staff had completed safeguarding training and those who spoke with the inspector were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. Safeguarding plans were developed and regularly reviewed; however, as previously mentioned control measure in these were not proving fully effective as allegations of abuse continued to occur. This was found to be impacting negatively on the quality and safety of care and support for residents.

Regulation 20: Information for residents

There was a residents' guide in place and available in the centre. It contained the

information required by the regulations. This included a summary of the services and facilities provided to residents, the terms and conditions of residency, arrangements for resident involvement in the running of the centre, how to access inspection reports, the complaints procedures, and arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by the risk management policies, procedures and practices in the centre. There were arrangements in place to ensure that risk control measures were relative to the risks identified. Arrangements were also in place for identifying, recording, investigating and learning from incidents, and systems for responding to emergencies. There were also reasonable measures in place to prevent emergencies.

Judgment: Compliant

Regulation 28: Fire precautions

There was suitable fire equipment provided and evidence that it was serviced as required. There were adequate means of escape and emergency lighting in place. Residents had personal emergency evacuation plans which clearly guided staff in relation to any support they may require to safely evacuate the centre, and the procedure for the safe evacuation of the centre in the event of an emergency was available, and on display. Fire drills were occurring regularly and there was sufficient evidence to indicate who took part, and any learning that occurred as a result of these drills was recorded and followed up on appropriately.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had an assessment that identified their health, personal and social care needs. These assessments were used to inform their plans of care which were being regularly reviewed and updated to ensure they were reflective of their needs. Residents were involved in the development and review of their personal plans, in an annual review of their plans.

Judgment: Compliant

Regulation 6: Health care

Residents had their healthcare needs assessed and care plans were in place to provide guidance for staff on how best to support them to stay healthy. They had access to allied health professionals in line with their assessed needs, and were supported to access national screening programmes in line with their health status and age profile, and in line with their wishes and preferences.

Judgment: Compliant

Regulation 8: Protection

Overall, the findings of this inspection were that the registered provider was failing to protect some residents from all forms of abuse. Allegations and suspicions of abuse were being reported and followed up on in line with the organisation's and national policy, and additional control measures implemented as part of safeguarding plans in the centre. However, the actions taken to date, and control measures implemented were not proving fully effective at the time of the inspection. They required review and further action to ensure that residents were happy, and felt safe in their home.

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 (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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community of Ireland Greenacres OSV-0003623

Inspection ID: MON-0038484

Date of inspection: 02/12/2022

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 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: - An emergency review meeting with the HSE Disability Manager of CH06 was scheduled for an immediate response plan. This meeting occurred on the 14th of December whereby CCoI proposed a number of measures that were needed to ensure both the immediate and long-term protection and safety of the residents of Greenacres. -A business plan was submitted on 3rd January 2022 for a sole occupancy for one CMSN. HSE advised that CMSN was at risk of placement breakdown due to the significant compatibility issues. In the interim CCoI has requested additional funding to provide 1:1 support for CMSN, additional psychological and psychiatric supports and funding to refer CMSN for a full cognitive assessment for accurate diagnosis and recommendations. -Bespoke training package scheduled for all staff in the areas of Safeguarding and Protection, Behavioural Support and Medication Management. All trainings scheduled to take place by Mid-February 2023. -Business case developed for CMSN who has presented as the VA in most safeguarding incidents for additional support for psychological and emotional well being. Key working sessions will also take place to encourage participation in same.	

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 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	30/04/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2023