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

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| Name of designated centre: | Fairview |
| Name of provider: | Gheel Autism Services Company Limited by Guarantee |
| Address of centre: | Dublin 3 |
| Type of inspection: | Short Notice Announced |
| Date of inspection: | 09 March 2021 |
| Centre ID: | OSV-0005301 |
| Fieldwork ID: | MON-0031331 |

## About the designated centre

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

Fairview designated centre consists of three residential homes, four individual occupancy apartments and one respite apartment. The houses, three purpose built single apartments and the respite apartment are located on the same site. One apartment is located 0.5Km away. They are home to 21 service users in total. The respite apartment is used to provide three service users with a respite stay for one night a week, two nights per week and three nights per week respectively. Fairview is situated in a suburban area of Dublin in close proximity to lots of local amenities and good public transport links. The immediate location offers a tranquil and calm atmosphere close to Dublin City. The aim of Fairview is to provide a residential setting wherein service users are supported and valued within a homely environment that promotes the independence, health and wellbeing of the service user. It is the aim that all staff in Fairview work with each service user on an individual basis on developing their own support plan to reflect all their needs and desires. Fairview accommodates both male and female service users over the age of 18 who have a diagnosis of Autistic Spectrum Disorder. Fairview specialises in providing residential and respite services in a personalised homely environment for the service users. The service user homes and apartments all have bathroom facilities, kitchen/dining room, living room areas, bedrooms, laundry facilities. There is access to a large garden for all of the residents. Each service user has their own bedroom. The support provided in the designated centre includes assistance with personal care, washing and laundry, supporting the development of life skills, cooking and provision of meals, support to go out in the community and maintain contacts in the community. All service users require a tailored level of support from staff, based on a mix of independence and abilities. Service users are supported by both social care workers and care workers and this is overseen by location managers.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 20 |

## 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 |
|---|---|---|---|
| Tuesday 9 March 2021 | 10:00hrs to 16:30hrs | Maureen Burns Rees | Lead |

## What residents told us and what inspectors observed

From what the inspector observed, there was evidence that the residents in the house visited had a good quality of life in which their independence was promoted. Appropriate governance and management systems were in place which ensured that appropriate monitoring of the services provided was completed by the provider, in line with the requirements of the regulations. The inspector observed that the residents and their families were consulted with regarding the running of the centre and played an active role in decision-making within the centre. Some area for improvement were identified in relation to maintenance and upkeep of the premises and documentation for individual risk assessments and personal plans.

The centre comprised of three houses, three purpose built single apartments and a respite apartment all located on a large campus based setting in the middle of Dublin. There was also one further self contained apartment located a short distance away but not on the campus. The respite unit could accommodate one resident at any one time and in total three residents availed of the respite service. The centre was registered to accommodate up to 22 residents. Residents living in the centre ranged in age from 30 to 74 years and had been living in the centre for a long period.

For the purpose of this inspection, the inspector visited one of the three houses which was home to four residents. The inspector met briefly with each of the four residents. Warm interactions between the residents and staff caring for them was observed. A number of the residents met with were unable to tell the inspector their views of the service but appeared in good form and comfortable in the company of staff. Two of the residents told the inspector that they were happy living in the centre and that staff were kind and helpful to them.

There was an atmosphere of friendliness in the house visited. Residents were heard happily conversing with staff who responded to their verbal and non verbal cues. Numerous photos of residents were on display. Staff were observed to interact with residents in a caring and respectful manner. For example, a behaviour of one of the residents was observed to be supported in a kind and dignified manner.

The house visited was found to be comfortable and homely. However, the paint on the walls and woodwork in the hallway and a number of the rooms on the first floor was observed to be worn and chipped in areas. In addition, the carpet and flooring in a number of areas appeared worn. A number of the bathrooms had been identified to be in need of refurbishment. The house had adequate space for residents with good sized communal areas. Each of the residents had their own bedroom which had been personalised to their own taste in an age appropriate manner. This promoted residents' independence and dignity, and recognised their individuality and personal preferences. There was a private garden to the rear of the house which had a number of sensory items on display and seating areas. The residents also had access to a number of large communal garden areas within the

campus. There was an outdoor room, swing, large poly-tunnel, orchard area with apple and pear trees and a chicken coup. One of the residents told the inspector that they enjoyed caring for the hens and collecting eggs for the centre, and planting and consuming some of the vegetables grown in the poly-tunnel. One of the outdoor buildings had been converted to a mini shop for residents' use to purchase snacks if so required as access for some residents to shops had been restricted due to COVID-19. Another area had been renovated into a cinema room which it was reported that residents enjoyed using.

There was some evidence that residents and their representatives were consulted with and communicated with, about decisions regarding their care and the running of their home. Each of the residents had regular one-to-one meetings with their assigned key workers. Residents were enabled and assisted to communicate their needs, preferences and choices at these meeting in relation to activities and meal choices. It was noted that COVID-19 and the national restrictions were discussed at resident's forum meetings on a weekly basis. The inspector did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had completed a survey with some relatives across the service which indicated that they were happy with the care being provided to their loved ones.

Residents were actively supported and encouraged to maintain connections with their friends and families through a variety of communication resources, including video and voice calls. All visiting to the centre was restricted in line with national guidance for COVID-19. A quality of life support plan had been put in place for individual residents in respect of COVID-19 and its impact on their life.

Residents were supported to engage in meaningful activities in the centre. In line with national guidance regarding COVID-19, the centre had implemented a range of restrictions impacting residents' access to activities in the community. It was noted that a 'quality of life gap analysis' to minimise the impact of COVID 19 on individuals had been completed by resident's key workers. Overall, it was reported that residents had coped well with the calmer pace of life during the pandemic. Each of the residents were engaged in an individualised programme coordinated from the centre which it was assessed best met the individual residents needs. A daily activity schedule was led by each of the residents. Examples of activities that residents engaged in included, walks to local scenic areas, drives, arts and crafts, card making, cooking, music therapy, mindfullness classes, board games, jigsaws, water and sensory games, bingo and listening to music. A number of residents also engaged in activities via video conferencing, such as chair aerobics, exercise classes 'nifty fifty', on-line concerts and a social club 'Golden Gheels'. The provider had its day service building on-site and a small number of the residents attended this service. All of the residents had access to a 'health and well being room' with exercise equipment and a multi-sensory area in the day service building. There were dedicated vehicles available for use by residents in each of the units. A horticulturist was part of the staff team and supported residents to grow a range of fruit and vegetables in the poly-tunnel and large communal gardens. Plans were in place for the residents to go on holidays over the summer period, pending national COVID-19

restrictions.

The majority of the staff team had been working in the centre for an extended period. This meant that there was consistency of care for residents and enabled relationships between residents and staff to be maintained. The inspector noted that residents' needs and preferences were well known to staff, the location manager and the person in charge.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

## Capacity and capability

There were management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs. Some areas for improvement are identified in relation to the care and support arrangements but a number of these had already been identified by the provider. For example the maintenance and up keep of the premises.

The centre was managed by a suitably qualified and experienced person. He had a good knowledge of the assessed needs and support requirements for each of the residents. The person in charge held a masters in risk management and systems change, a diploma in supported employment and a degree in social care. He had more than 20 years management experience. He was in a full time position and was not responsible for any other centre. He was found to have a good knowledge of the requirements of the regulations. The person in charge reported that he felt supported in his role and had regular formal and informal contact with his manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by four location managers across the centre. The person in charge reported to the operational manager who in turn reported to the chief executive officer. The person in charge and operational manager held formal meetings on a regular basis. In addition the person in charge had regular formal meetings with the location managers which promoted effective communication across the centre.

The provider's quality auditors had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six monthly basis as required by the regulations. The person in charge had undertaken a number of audits and other checks in the centre on a regular basis. Examples of these included, quality and safety walk around, quality of life thematic audit, medication practices, finance and staff documentation. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separately management meetings with evidence of

communication of shared learning at these meetings. Quarterly quality and safety reports were compiled which considered trends in incidents and their management, and key performance indicators.

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents in the house visited. At the time of inspection, the full complement of staff were in place. This provided consistency of care for the residents. The actual and planned duty rosters were found to be maintained to a satisfactory level. The provider had completed formal dependency assessments to determine the level of supports required by residents.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. There was a staff training and development policy. A training programme was in place and coordinated by the location managers. There were no volunteers working in the centre at the time of inspection. Suitable staff supervision arrangements were in place. This was considered to support staff to perform their duties to the best of their abilities.

A record of all incidents occurring in the centre was maintained and overall where required, these were notified to the Chief Inspector, within the timelines required in the regulations.

## Regulation 14: Persons in charge

The person in charge was found to be competent, with appropriate qualifications and management experience to manage the centre and to ensure it met its stated purpose, aims and objectives.

Judgment: Compliant

## Regulation 15: Staffing

The staff team were found to have the right skills, qualifications and experience to meet the assessed needs of the residents in the house visited. At the time of inspection, the full complement of staff were in place.

Judgment: Compliant

## Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve

outcomes for the residents. All staff in the house visited had attended mandatory training.

Judgment: Compliant

## Regulation 23: Governance and management

There were suitable governance and management arrangements in place. The provider had completed an annual review of the quality and safety of the service and unannounced visits to review the quality and safety of care on a six-monthly basis as required by the regulations.

Judgment: Compliant

## Regulation 31: Notification of incidents

Notifications of incidents were reported to the office of the chief inspector in line with the requirements of the regulations.

Judgment: Compliant

## Quality and safety

The residents living in the house visited, appeared to receive care and support which was of a good quality, person centred and promoted their rights. However some improvements were required regarding the upkeep of the premises and procedures in place to review individual risk assessments.

Overall the residents' well-being and welfare was maintained by a good standard of evidence-based care and support in the house visited. Daily living support plans reflected the assessed needs of individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social care needs and choices. Vulnerability assessments had been completed to analyse individual resident's support needs. There was evidence that person centred goals had been set for each of the residents and there was good evidence that progress in achieving the goals set were being monitored. An annual personal plan review for each of the residents in the house visited had been completed. These reviews involved consultation with family members via virtual meetings in light of COVID-19 visiting restrictions.

The health and safety of the residents, visitors and staff were promoted and protected. However, it was noted that individual risk assessments for a number of the residents had not been reviewed for an extended period. This meant that measures in place to control and manage the risks identified might not still be valid. There was a service and care risk register in place. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. Trending of all incidents was completed on a quarterly basis. This promoted opportunities for learning to improve services and prevent incidences.

Suitable precautions were in place against the risk of fire. There was documentary evidence that fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the house visited. There were adequate means of escape and a fire assembly point was identified in an area to the front of the house. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Fire drills involving the residents had been undertaken at regular intervals and it was noted that the centre was evacuated in a timely manner.

There were procedures in place for the prevention and control of infection. A COVID-19 contingency plan had been put in place which was in line with the national guidance. The inspector observed that areas in the house visited appeared clean. A cleaning schedule was in place which was overseen by the person in charge and location manager. Colour coded cleaning equipment was in place. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. Specific training in relation to COVID-19, proper use of personal protective equipment and effective hand hygiene had been provided for staff. Staff and resident temperature checks were being taken at regular intervals on all entries and exits from the centre. Disposable surgical face masks were being used by staff whilst in close contact with residents in the centre, in line with national guidance.

There were measures in place to protect residents from being harmed or suffering from abuse. Allegations or suspicions of abuse had been appropriately reported and responded to. In the preceding period, there had been some compatibility issues in one of the houses but this had been addressed by the provider with the transition of a resident to a more suitable placement. The provider had a safeguarding policy in place. Intimate care plans were on file for each of the residents in the house visited and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents. Capacity assessments for management of financial affairs had been completed for individual residents so as to determine the level of support required to manage their individual finances.

Residents were provided with appropriate emotional and behavioural support and their assessed needs were appropriately responded to. Support plans were in place for residents as required, and from a sample reviewed, these provided a good level

of detail to guide staff. A small number of environmental restrictions were used in one of the units and these were subject to regular review. In-house analysis and observations of behavioural incident reports were completed so as to manage any such incidents and prevent re-occurrence.

## Regulation 10: Communication

Residents' communication needs were met. There was a policy on communication. Individual communication requirements were highlighted in residents' personal plans. There were communication tools, such as picture exchange and object of interest in place, to assist residents identified to require same, to choose diet, activities, daily routines and journey destinations.

Judgment: Compliant

## Regulation 17: Premises

The house visited was found to be comfortable and homely. However, the paint on the walls and woodwork in the hallway and a number of the rooms on the first floor was observed to be worn and chipped in areas. In addition, the carpet and flooring in a number of areas appeared worn. A number of the bathrooms had been identified to be in need of refurbishment.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. However, it was noted that individual risk assessments for a number of the residents had not been reviewed for an extended period.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

There were suitable procedures in place for the prevention and control of infection which were in line with national guidance for the management of COVID-19. A cleaning schedule was in place and the house visited appeared clean. A COVID-19

preparedness and contingency plan was in place which was in line with the national guidance.

Judgment: Compliant

## Regulation 28: Fire precautions

Suitable precautions were in place against the risk of fire. Fire fighting equipment, emergency lighting and the fire alarm system were serviced at regular intervals by an external company. There were adequate means of escape. A procedure for the safe evacuation of residents in the event of fire was prominently displayed in the house visited.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Residents' well being and welfare was maintained by a good standard of evidence-based care and support. Individual support plans reflected the assessed needs of the individual resident and outlined the support required in accordance with their individual health, personal and social care needs and choices. Quality of life gap analysis had been completed with the aim to minimise the impact of COVID-19 restrictions on residents lifes.

Judgment: Compliant

## Regulation 6: Health care

Residents' healthcare needs appeared to be met by the care provided in the centre. Individual health assessments and plans were in place. There was evidence residents had regular visits to their general practitioners (GPs). Residents had access to a registered nurse who was based on the campus. There was evidence that dietary guidance for individual residents was being adhered to.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional and behavioural support. Behaviour support plans were in place for residents identified to require same and these were subject to regular review.

Judgment: Compliant

## Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. Allegations or suspicions of abuse had been appropriately reported and responded to. Intimate and personal care plans in place for residents identified to require same, provided a good level of detail to support staff in meeting individual resident's intimate care needs. Safeguarding information was on display and included information on the nominated safeguarding officer.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents' rights were promoted by the care and support provided in the centre. Residents had access to advocacy services should they so wish. There was information on rights and advocacy services observed on the notice board. There was evidence of active consultations with residents regarding their care and the running of the house. Residents' meetings were completed on a monthly basis. Residents' rights were noted to be discussed at these meetings.

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 | Compliant |
| Regulation 23: Governance and management | Compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Fairview OSV-0005301

## Inspection ID: MON-0031331

## Date of inspection: 09/03/2021

**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 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>The PIC has conducted an audit on the premises and actioned work to be completed in relation to the bathrooms, flooring and painting to address the issues highlighted in the report. The home has now been painted. Bathrooms and flooring will be upgraded in April – May 2021 as actioned to the maintenance team and the PIC will unsure the work is completed within this timeframe – by 31st May 2021.<br><br>Gheel has partnered with MPM Property Management Limited (MPM) for the delivery of maintenance services to our organisation effective from 07/Jan/2021 to unsure premises are maintained to the highest of standards going forward.<br><br>MPM is a nationwide company that specialises in responsive repairs, planned maintenance, property renovations and improvements. MPM is a multi-service company that provides the following services:<br>• General Maintenance<br>• Heating & Plumbing<br>• Electrical<br>• Leak Detection and CCTV Surveys<br>• Garden Maintenance<br>• Building Fabric maintenance and repairs | |
| Regulation 26: Risk management procedures | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 26: Risk management procedures: | |

The process of reviewing individual risk management plans is underway and all will be reviewed in April – May 2021 in partnership with the people we support by the PIC, Location Manager, key workers, and the circle of support to mitigate the risks highlighted in the report. The PIC will oversee this process, ensure timelines are adhered to and this will be completed by 31st May 2021.

A schedule has been developed by the PIC to ensure individual risk management plans are reviewed going forward twice annually and as needed should new risks emerge. The PIC will ensure this schedule is implemented.

## 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 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 31/05/2021 |
| 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 | 31/05/2021 |