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:	Fairview
Name of provider:	Gheel Autism Services CLG
Address of centre:	Dublin 3
Type of inspection:	Announced
Date of inspection:	06 February 2025
Centre ID:	OSV-0005301
Fieldwork ID:	MON-0037614

About the designated centre

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

Fairview is a designated centre operated by Gheel Autism Services CLG. The designated centre is comprised of multiple housing units, most of which are located on the provider's campus. On campus, there are three group houses and five single occupancy apartments and an off-campus, one single-occupancy house. The centre has capacity to accommodate 18 service users in total. Fairview designated centre is situated in a suburban area of Dublin in close proximity to local amenities and good public transport links. In the designated centre, there is a focus on supporting individuals with autism through their life journey and enabling them to have fulfilling life experiences, while having autonomy and control over their choices and decisions. Within the model of support, the staff team actively contribute to the fostering of positive relations with the local community and in particular with those living in the immediate neighbourhood to build networks and connections with the people supported to enhance their community participation and quality of life. The centre is managed by a person in charge who is supported in their role by location managers and a staff team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
Thursday 6 February 2025	10:00hrs to 17:30hrs	Jennifer Deasy	Lead
Thursday 6 February 2025	10:00hrs to 17:30hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

This inspection was an announced inspection scheduled to inform decision making in respect of registration renewal. The inspection was completed by two inspectors who visited all of the premises which comprise the designated centre. Inspectors had the opportunity to meet with many of the residents over the course of the day and to speak to key staff. Inspectors used conversations, observations of care and support and a review of documentation to inform decision making in respect of the quality and safety of care.

Overall, inspectors found that the provider had taken measures to address risks identified on previous inspections in respect of the premises and fire safety precautions. However, there remained enhancements required to the governance and management arrangements of the centre to ensure oversight of the quality and safety of care.

The designated centre is located close to Dublin City Centre. It comprised of four separate buildings on a campus-style setting which were home to 15 residents on the day of inspection. Some of these buildings provide individual, apartment-style accommodation for residents, while other houses provide accommodation to a group of residents who have their own bedrooms but share communal facilities such as kitchens and living rooms. There are also offices and day services on the shared site. The centre also comprised a standalone apartment for one resident that was located off-site but within a short walking distance to the other premises.

This centre has been in escalation within the current regulatory cycle. Three inspections since June 2023 had identified non-compliance in the areas of governance and management, infection prevention and control, fire precautions and premises. The provider had committed through their compliance plan responses to address these areas. Inspectors saw, on a walk around of the designated centre, that the provider had completed significant works to enhance the premises of the designated centre. These works included tidying the grounds of the campus, replacing designated centre windows and doors, refurbishing bathrooms and replacing flooring.

The provider had completed a review of the fire precautions and it was evident that work had been completed to address fire safety risks. For example, new fire doors with automatic door closers were installed, thumb locks were provided on all exit doors and staff had received enhanced fire safety training.

The works completed to the premises were effective in enhancing the infection prevention and control management systems. Inspectors saw adequate hand hygiene facilities and cleaning equipment which was in line with the National Standards. For example, colour coded mops, buckets and cloths were provided for in the houses.

Inspectors saw that residents were living in homes which were homely, comfortable and clean. Residents appeared to be relaxed in their homes. Inspectors saw residents accessing their bedrooms to rest, their sitting rooms to watch TV and the kitchen for drinks and snacks. In one house, a resident showed an inspector the new bathroom with an accessible bath which had been recently installed. Staff told the inspector that the residents enjoyed the bath and that it was enhancing the quality of care provided to them. A second bathroom in this house was seen to require an upgrade. The inspector was told that an occupational therapy assessment was underway at the time of inspection to inform the refurbishment of the second bathroom.

In a second house an inspector met three residents who lived there. Two of the residents were watching TV and told the inspector how they planned to go out to visit their family and to have a coffee later that day. The residents told the inspector about their favourite places to go for coffee and other activities that they enjoyed accessing in the community. The inspector met one resident who was having a rest day and had chosen to have a lie in. The resident chatted to the staff about the lunch menu and their plans for the afternoon which included going for a drive and getting tea and cake. Staff were seen to interact with residents in a kind and gentle manner.

In another house, the inspectors saw that the provider had completed significant premises works since the last inspection. This included upgrading bathrooms and providing a clean and well-maintained individual bathroom for each of the residents. New windows and doors had been installed. All residents in this house had gone out for the day. The inspector was told that they availed of individualised services and chose preferred activities to engage in with the support of staff.

An apartment which was attached to one of the houses was not viewed by inspectors due to the needs and preferences of the resident who lived there. Inspectors were told that this apartment required refurbishment and that the provider had plans to develop an individual living service for this resident.

In the campus based adjoining apartments, three residents were not present during the inspection as they were attending day services and different social activities such as the cinema. Two residents declined to meet the inspectors. However, the inspector briefly observed the location manager engaging with the residents, and saw that they were very kind and responsive to their needs. The resident living in the off campus apartment was not present during the inspectors' visit to their home.

Inspectors also observed an unsafe practice on the main campus that they brought to the attention of the senior management team: the pedestrian gate to exit the campus was locked and pedestrians were observed walking on the road and and putting their hand through the bars of the main gates (used by vehicles) to access an exterior keypad. This practice posed a safety risk, and the locking of the gate also presented a potential restrictive practice that had not been recognised by the provider.

Inspectors spoke with a number of staff over the course of the day. One staff told

inspectors that they were proud of the care and support which they provided to residents. They described to the inspector how they supported residents to engage in meaningful activities and to access the community. This staff described how they supported residents who communicated in non-verbal means and showed the inspector some of the visual communications systems which were used.

A location manager told inspectors that significant improvements had been made to the service since the previous inspection in 2024. The improvements included enhanced infection prevention and control enhancements, upgrades to the fire safety systems, renovation of the premises, and better staff knowledge of risk management and escalation. They said that residents received good quality and person-centred care and support, and that the staff were committed to supporting their needs and wishes. They said that staff promoted residents' rights by preparing information in easy-to-read formats for them understand, and by supporting residents to choose and achieve personal goals.

Overall, inspectors saw that residents were in receipt of person-centred care and support from a staff team who knew them well and were committed to upholding residents' rights. Inspectors saw that the provider had taken steps to come into compliance in particular in respect of premises and fire safety risks. However, there remained improvements to the oversight arrangements in order to continue to drive service improvement, to ensure regulatory compliance and ultimately to ensure that residents were in receipt of a safe and good quality service.

Capacity and capability

This section of the report describes the governance and management arrangements and how effective these were in ensuring a good quality and safe service. Inspectors found that the residents were supported by a consistent staff team who knew their needs and individual preferences well. The provider had taken steps to enhance the oversight arrangements, for example by appointing location managers and a social care leader to support the person in charge in their role; however, there remained improvements required to the management systems to ensure that the service was consistently and effectively monitored, and to enable the provider to self-identify areas for improvement.

This was an announced inspection scheduled to inform a registration renewal decision. The registered provider was required to make an application to renew the centre's certificate of registration within a defined time frame. This was communicated to the provider by the Chief Inspector on several occasions by email, over the phone, and in person, prior to and during the inspection of the centre; however, an application was not received by the Chief Inspector within the time period required. This meant the provider was not adhering to the requirements of the Health Act 2007 (as amended) and the provisions set out under Section 48 of

the Act.

Inspectors also communicated to the provider, two days in advance of the inspection, regarding the documents which they wished to review on the day. This afforded the provider time to prepare these documents. Requested documents included the staff training records and the Schedule 5 policies. The requested documents were found to be incomplete and were not available for a full review on the day of the inspection. Inspectors could therefore not establish if all staff had the required mandatory training. Schedule 5 policies were difficult for managers to access and only a sample of these were made available for review. It was not demonstrated that policies were being utilised in the centre to guide staff in their everyday work.

The provider had made changes to the oversight arrangements of the centre. Location managers and a social care leader had been appointed; however, inspectors found that these managers did not all have protected management time in order to fulfill required duties. Additionally, managers did not have access to key systems to support them in having oversight, for example location managers did not have access to the centre's risk register.

The provider's own audits were ineffective in identifying service risks and in implementing action plans in order to drive service improvements. Audits did not identify gaps in regulatory compliance as identified on this inspection. Actions plans were not fully completed and failed to allocate a responsible person or a time frame to each action required.

The provider had effected a complaints policy and procedure. Inspectors saw that this was in an accessible format for the residents.

Overall, there remained improvements required to the governance and management of the centre. The lack of a full suite of policies and of robust management arrangements posed risks to the oversight and delivery of safe care in the centre.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew the centre's certificate of registration was not received by the Chief Inspector within the required time frame.

This meant the provider was not adhering to Section 48 of the Health Act 2007 (as amended).

In addition, the provider's failure to submit a full and complete application within the required time frame and in a correct manner meant the provider was unable to avail of the protections of Section 48 of the Health Act (2007).

These matters were verbally outlined to the provider on the day of inspection and the provider committed to submitting an application; however, at the time of writing

the report, an application had not yet been received.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had ensured that the staff skill-mix and complement was appropriate to the needs and number of residents living in the centre. The chief executive officer and local managers spoken with told inspectors that they were satisfied with the arrangements.

The skill-mix comprised location managers, social care workers and care workers. There were also nurses on campus to oversee residents' healthcare plans. There was a small number of vacancies. However, the provider was recruiting to fill the posts, and there were appropriate interim arrangements to support residents' continuity of care. For example, regular relief staff were used to cover vacant shifts.

Inspectors reviewed a sample of the recent staff rotas for the on campus apartments. They were well maintained, and clearly showed the names of the staff working in the centre, and the hours they worked.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff had received appropriate training as part of their professional development and inspectors found that the provider's oversight of this matter was poor. This posed a risk to the quality and safety of the care and support they provided to residents in the centre.

Inspectors reviewed a staff training log with the chief executive officer. The log was not comprehensive, and did not include all relevant training programmes. The inspectors had emailed the provider two days in advance of the inspection to inform them that they planned to review the log. However, the provider failed to ensure that the log was readily available, comprehensive and up to date on the day of the inspection.

The training log provided to inspectors showed that staff required training in several areas including fire safety, behaviour support, first aid, communication, and infection prevention and control. Additionally, as noted under regulation 10, not all staff had received communication training where required. The absence of fundamental staff training posed a risk to residents' safety and wellbeing.

The provider's oversight of the staff supervision also required improvement. The

associated policy could not be retrieved by management staff during the inspection, and two local managers provided conflicting information about the frequency of formal supervision to be provided to staff. Additionally, although inspectors were told that staff attended team meetings as part of the supervision arrangements, records of the minutes were not provided to inspectors as requested during the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The inspectors found that the provider's oversight mechanisms were ineffective in self-identifying risks and ensuring that the service was safe and consistently and effectively monitored. The provider had taken action to address areas of non-compliance identified by inspectors within the current regulatory cycle; however, inspectors identified a number of additional regulations as not compliant on the current inspection. It was not evident that the provider's management systems and audits were effective in identifying concerns in respect of the safety and quality of care and implementing a plan to address these concerns.

The provider outlined, through their previous compliance plan responses, how they had taken steps to enhance the oversight arrangements. A social care leader had been employed and a line manager was appointed for one to two of each of the buildings which comprised the designated centre. However, inspectors were told that some line managers had insufficient protected management time in order to fulfill their duties. Inspectors also saw that line managers did not have access to key systems required to support them in having oversight. For example, line managers did not have access to the risk register and two managers, when asked to locate a schedule 5 policy, could not locate this on the provider's intranet.

The provider's audits were ineffective in identifying all risks and in driving service improvement. Inspectors reviewed the most recent six monthly audit from November 2024. Inspectors saw that this audit did not identify gaps in regulatory compliance as found by inspectors on this inspection, for example in regulation 4 and 12. Additionally, when issues were identified, the action plans to address these were not always assigned to a responsible person and, for some actions, there was no time frame allocated. For example the audit identified that a review was required of residents' social care assessments; however there was no time frame for this to be completed by and the action was not allocated to a responsible person.

As noted under registration regulation 5, the provider had failed to apply to renew the registration of the centre within the required time frame. Although, inspectors reminded the provider during the inspection to submit an application, no application had been received at the time of writing this inspection report.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had effected a complaints policy which was reviewed and was seen to be up-to-date. Inspectors saw that there was accessible information throughout the designated centre to residents to inform them of the complaints procedure. Inspectors were told that there had been no complaints made by residents within the past 12 months.

Judgment: Compliant

Regulation 4: Written policies and procedures

As this was an announced inspection the provider was informed in advance of the documents which inspectors wished to review on the day. The documents requested prior to the inspection included all Schedule 5 policies. These policies were difficult to access by line managers and service managers on the day of inspection and so all Schedule 5 policies could not be reviewed by inspectors.

Inspectors reviewed 12 out of the required 21 Schedule 5 policies. These 12 policies were the only ones which could be made available for review on the day of inspection. Of these, four were out of date and two were in draft form, having been recently reviewed. The provider did not have the full suite of policies as required by the regulations on the day of inspection.

Inspectors asked to see a copy of the provider's policy on medication management; however, it was found that the provider did not have their own policy and instead used the National Framework for Medicines Management in Disability Services. This did not provide guidance to staff on the specific systems and procedures in place for the management of medications within the designated centre.

Improvements were required to ensure that the provider had the full suite of Schedule 5 policies available and easily accessible to all staff. These are required in order to ensure that staff have guidance in the provision of appropriate care and support to residents.

Judgment: Not compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. Inspectors found that the provider had implemented actions as detailed in their compliance plan responses in order to address premises and fire safety risks. However, inspectors found a number of regulations not compliant on this inspection in areas such as personal possessions and risk management. These risks had not been self-identified by the provider and posed risks to the safety and well being of residents. In particular, improvements were required to the oversight of residents' finances to ensure that these were safeguarded and to the risk management systems.

The registered provider had completed significant upkeep to the buildings that comprised the designated centre subsequent to the last inspection. New bathrooms had been installed and old bathrooms had been refurbished, new flooring was fitted and a number of the houses had new furniture and fittings. Overall, the premises of the centre was seen to be clean, homely and comfortable. There remained some upkeep required to two bathrooms and to one of the communal kitchens. Inspectors were told there was a plan in place to complete this work.

The maintenance works had included improvements to the fire safety procedures in the centre. Fire doors with automatic door closers had been installed and exit doors were fitted with thumb locks. Staff had been provided with enhanced fire safety training and staff spoken with were informed of their roles and responsibilities in respect of fire safety. The provider had contracted a fire safety company to complete regular upkeep on fire doors, fire panels and fire extinguishing equipment. External lighting had been installed to aid the evacuation of residents.

Residents' individual assessments and personal plans were reviewed by inspectors. Inspectors saw that enhancements were required to residents' care plans and, in particular, to financial care plans. A sample of residents' files reviewed showed that each resident had an up to date assessment however a number of care plans were out of date and required review. Some residents did not have financial care plans, and those that did, were incomplete and missing key information about how best to support residents with their finances. While residents had communication care plans, inspectors found that not all staff had received training in the residents' communication methods. For example, one resident used sign language to communicate but only one staff member had completed this training.

Inspectors saw that safeguarding incidents were investigated and reported to the Chief Inspector and the national safeguarding and protection team. Safeguarding plans were implemented and staff spoken with were knowledgeable regarding their safeguarding responsibilities.

Improvements were required to the provider's risk management systems, in particular in respect of identifying and managing hazards and incidents appropriately. As previously described, inspectors pointed out a hazard in respect of the main gate to the provider on the day of inspection. There was also an absence of suitable policies and local operating procedures to guide staff in managing adverse incidents.

Overall, while the provider had clearly taken steps to enhance the premises and fire safety precautions, there were a number of areas for improvement identified on this inspection. Many of these areas of non compliance had not been identified by the provider and posed risks to the safety and well being of residents.

Regulation 10: Communication

Inspectors found differing findings in respect of communication across the houses which comprised the designated centre. In some houses, staff were clearly informed regarding residents' communication needs and spoke with inspectors of how they supported residents in understanding information and making choices. In other houses, staff were informed of residents' communication needs however they had not received specific training in areas such as sign language as used by residents.

In one of the houses, an inspector was told by staff how they were supporting residents who communicated through non-verbal means to have choice and control in their everyday lives. Staff described how residents' files contained communication dictionaries and how all new staff were informed of these dictionaries on induction. Staff described trialling different activities with residents and interpreting their non-verbal communication to determine if these activities were meaningful and enjoyable for residents.

Staff in this house described allowing flexibility in routines and for residents to change their mind in respect of their choices. Some residents used objects to communicate. For example, staff described how one resident will get their shoes and coat to indicate that they wish to go for a walk. Inspectors saw that communication plans for residents in this house detailed residents' individual communication methods including using pictures and other non-verbal modes.

Inspectors also reviewed the communication plans for two residents living in the adjoining apartments. One resident used manual signs to communicate. However, staff had not received training on using the signs and there was no guidance for staff to refer to. The other resident's communication care plan was found to require more detail to clearly outline their preferred communication mode and literacy.

The resident living in the off-campus apartment used sign language as part of their communication means. However, inspectors were told that only one staff member had received sign language training. The absence of appropriate and specific communication training and guidance for staff posed a risk to how effectively they communicated with residents, and how residents were supported to express themselves.

The registered provider had ensured that residents had access to various media sources including televisions, smart devices, and the Internet.

Judgment: Substantially compliant

Regulation 12: Personal possessions

There was an absence of an up-to-date policy, care plans and local operating procedures to guide staff in the management of residents' finances. This posed a risk to the financial safeguarding of residents.

The provider's policy in respect of the management of residents' personal property, personal finances and possessions was out of date and required review.

Inspectors reviewed five of the residents' files in respect of their financial care plans with the service manager on the day of inspection. Inspectors saw that three of the residents had no financial care plans or information on how to support them in managing their finances. Two residents had financial care plans however they were insufficiently detailed. For example, one resident's care plan detailed that they required someone to be legally responsible for their finances and the arrangements for this should be detailed in Section F of "How to Support Me"; However, on review by inspectors, section F was seen to be blank and did not provide this information. It was not evident how residents were being supported with their finances in the designated centre.

Inspectors requested to review the personal property inventory forms (as referred to in the provider's policy) for five residents living in the adjoining apartments. The local manager told the inspectors that there were no forms maintained for the residents. The provider's quality team had noted discrepancy in a recent audit; however, the matter had not yet been rectified. This demonstrated poor oversight and implementation of the provider's policy.

Judgment: Not compliant

Regulation 17: Premises

Inspectors saw that the provider had made considerable improvements to the premises of the designated centre. In the three group houses new bathrooms had been created and old bathrooms had been refurbished to a high standard. New flooring was installed along with new windows and doors where required. Some of the houses had received new furniture. Overall, the houses were very clean and homely.

The group houses were decorated with photographs of residents and the inspectors saw that residents' bedrooms were personalised and had adequate storage for

residents' possessions. Communal areas were comfortable and were decorated in line with the profile of residents who accessed them. For example, one house provided sparkly cushions and soft throws in line with the residents' sensory and personal preferences.

There were some minor areas which required upkeep. In one of the houses, a bathroom required refurbishment. The inspectors were told that an occupational therapy assessment was underway at the time of inspection to inform the refurbishment and ensure it was in line with residents' assessed needs.

One house required minor upkeep to the kitchen due to worn countertops and a damaged fridge. The inspector was told that there were plans to complete this work.

In the apartments, inspectors saw that works had been completed to upgrade the bathrooms and the fire containment measures. Residents' apartments were decorated in line with residents' personal tastes, for example with pictures and family photographs. The utility room had been reorganised to mitigate against infection prevention and control and fire hazards. One staff ensuite required some upkeep. For example, floor tiles needed regrouting, the unit around sanitary ware was damaged and the door was water damaged.

The off campus apartment was clean, tidy, homely, personalised, warm, and well maintained and equipped.

Overall, the provider had completed significant works to the premises. These works were effective in ensuring that residents were living in clean, comfortable and homely environments. There remained some upkeep required to two bathrooms and to one kitchen.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared an up-to-date risk management policy. The policy outlined the arrangements for identifying, analysing, escalating, managing and monitoring risks. However, the provider's arrangements for identifying and monitoring risks in the centre required improvement, particularly to ensure that management staff were able to access crucial information.

There were different risk registers including a health and safety and centre level register. However, two local managers spoken with were unable to access these risk registers (inspectors were informed that only the person in charge, executive management team, and the provider's quality team could access them). This posed a risk to how effectively local managers and staff were able to understand risks within the centre, and the associated control measures that were to be in place.

Inspectors reviewed a sample of the residents' individual risk assessments (which

local managers could access) and the risk assessments on the centre's risk register. Inspectors found that some control measures outlined in the risk assessment, such as staff training in specific areas, were not in place. Therefore, the effectiveness of these measures was compromised. This issue had not been identified by the provider. Inspectors also found that residents' individual risk assessment required better maintenance and detail. For example, the use of a restrictive practice was not noted in an associated risk assessment, and not all risk assessments had been risk rated. Inspectors also observed an environmental practice (a locked exit) in one apartment that had not been subject to a risk assessment. Therefore, it was not demonstrated that the practice was proportionate to the risk.

Additionally, inspectors found that hazards were not being recognised and managed appropriately by the provider. Inspectors observed an unsafe practice on the main campus that they brought to the attention of the senior management team: the pedestrian gate to exit the campus was locked and pedestrians were observed walking on the road and and putting their hand through the bars of the main gates (used by vehicles) to access an exterior keypad. The management team spoken with were unclear about how long it had been locked and on the reason for it being locked. This practice posed a safety risk, and the locking of the gate also presented a potential restrictive practice that had not been recognised by the provider.

The provider's arrangements for managing incidents also required improvement. The provider's risk management policy referred to the provider's incident management policy. However, inspectors were told that the policy was no longer in use and instead the provider solely used their funder's incident management framework. Therefore, there was an absence of a local policy that outlined the provider's specific arrangements and procedures for staff to follow. This posed a risk of inconsistent practices.

Incidents were reported on the provider's electronic information system. Inspectors reviewed the entries in the previous 12 months, and found that several incidents, including medication errors and incidents, had not been 'closed'. Therefore, it was not demonstrated that incidents occurring in the centre had been appropriately reviewed or that actions were put in place to reduce the likelihood of the incidents recurring. Additionally, inspectors found that the 'closed' incidents could not be accessed by local managers. This meant that they could not utilise information from the incidents to inform their risk control measures or as part of a review of trends of incidents.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had undertaken a full review of their systems for the detection, containment and extinguishing of fires in the designated centre subsequent to the previous two inspections. This review had identified the need for the installment of

new fire containment equipment and enhanced training for staff in fire safety.

Inspectors saw, on a walk around of the centre, that significant work had been completed in respect of fire containment. For example, new fire doors were fitted throughout the centre in order to compartmentalise buildings and to ensure that fire and smoke would be restricted from residents' bedrooms. Fire doors were fitted with automatic door closers. The provider had also contracted a fire safety company to complete quarterly checks of their fire doors.

Escape routes from the designated centres had been enhanced by installing emergency lighting outside to illuminate residents' exits. Exit doors had also been fitted with thumb locks to enable a swift exit from the building. Staff spoken with described the additional training in respect of fire safety. Staff spoke about their responsibilities in completing weekly and monthly fire safety checks. Staff were also informed of the emergency plan and of how to assist residents to evacuate in the event of an emergency.

Each building of the centre was fitted with a zoned fire panel to aid the location of a fire and the safe evacuation of residents.

Inspectors also saw that there was internal emergency lighting and that the premises of the centre were fitted with fire blankets and extinguishers which were regularly services.

Overall inspectors saw that the provider had implemented their actions in respect of fire precautions as detailed in their compliance plan and that these actions were being effective in enhancing the fire safety procedures in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed four of the residents' individual assessments and care plans. Inspectors saw that each resident had an individual assessment which had been reviewed within the past 12 months. The assessment was person-centred and rights-informed and clearly detailed residents' preferences in respect of their care and support. The assessment also detailed how to involve residents in decision-making and described how residents' communicate consent or non-consent.

The assessment was used to inform care plans in respect of assessed needs. Inspectors saw that some of these care plans had not been updated within the past 12 months as required by the regulations. For example, a personal care plan was two years out of date. This posed a risk that staff may not have been informed of changes to residents' care needs and may have been providing care which was not in line with current health care needs.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had effected a policy to guide staff in their safeguarding procedure. This policy had been recently reviewed and updated as required by the regulations. Inspectors reviewed the documentation in respect of three recent incidents of alleged abuse in the designated centre. Inspectors saw that these incidents had been reported to the Chief Inspector and the safeguarding and protection team in a timely manner. Interim safeguarding plans were implemented to protect residents from abuse. Inspector saw that the safeguarding and protection team had agreed with the safeguarding plans and approved these as formal safeguarding plans.

Staff spoken with were aware of residents' needs in respect of safeguarding and of the measures that had been implemented in line with safeguarding plans. Staff were aware of the reporting procedure for safeguarding concerns.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Fairview OSV-0005301

Inspection ID: MON-0037614

Date of inspection: 06/02/2025

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: • The provider has ensured the Quality and Safety team (Q&S) have designed a Schedule of Work. This includes a comprehensive review of the Statement of Purpose and all necessary documentation (bi-annually) required for registration. This will ensure that the application is ready for submission well in advance of the next registration period. This was completed on 6th March 2025.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The provider with the Learning and Development team (L&D) team have enhanced management oversight by improving the functionality of the internal training platform (GRASP) to ensure all training records are comprehensive and up-to-date. • L&D team are currently creating a comprehensive training plan, migrate and cross-check existing records, and establishing a centralised location for all training documentation. Completion by 30th May 2025. • The provider will ensure that, post-migration, the Person in Charge (PIC) verifies all staff have completed or are enrolled in mandatory training, including refreshers, by 30th June 2025. • Additonally, the PIC will Integrate mandatory training management and compliance into a DC continuous professional development program, managed by LM/SCMs and	

overseen by the PIC and Q&S team. Mandatory training will be included in internal audits, team meetings, and staff supervisions. The PIC will also oversee staff training renewals supported by the LM/SCMs as an ongoing process and feature as a standing agenda during DC meetings to ensure continuous compliance.
• The provider has implimented monthly regional network team meetings to ensure oversight of training compliance across the DC (Now in place).
• The provider is committed to a full review of Schedule 5 policies to include reviewing and updating our supervision policy to ensure it is easily accessible to all management and to ensure consistency of the implementation and understanding of the supervision frequency. A full review of schedule 5 policies will be completed by the 30th of June 2025.
• The PIC has established a centralised system for recording and storing minutes of team and individual supervisions to ensure they are readily available for all staff (now in place).
• The PIC has established a system for storing staff supervisions (now in place).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The provider is committed to improving oversight mechanisms to ensure the safety and quality of care. All LM and SCM will now be included in Risk Register reviews every three months with the Q&S team and PIC. Additionally, risk registers will be maintained on the GRASP to ensure they are easily accessible and up to date. This will help us proactively identify and address potential risks, ensuring a safer and more effectively monitored service. This will also be reviewed on a monthly basis during our regional network team meetings. The next review of the risk registers will be the 16th April 2025.

• The provider is committed to recruiting the second SCM which has progressed to interview stage at 13/03/25. This position will be supernumerary and will not be a front-line post, resolving the issue of protected time for administration. Both appointed SCMs will complete the PIC training required and will have this training completed within 12 months by 18th of March 2026.

• Additionally, the provider will ensure that all managers have access to key systems, including the risk register and Schedule 5 policies, to support them in their oversight duties. A full review of Schedule 5 policies will be completed by the 30th of June 2025.
• The provider will ensure all internal audits will be conducted every quarter to include: two bi-annuals (Q&S) and two walkarounds (PIC/SCM) to ensure continuous monitoring and improvement. This will enable more effective management of action plans and clearly assign responsibilities and time frames. The next quarterly audit will be completed by 30th April 2025.
• The Q&S will use a specific Microsoft list that will track progression of all actions from

audits to ensure responsibility and timeframes are assigned and actioned. Additionally, the Q&S team will review and improve the bi-annual audit template to ensure it captures all regulatory requirements. The next quarterly audit will be completed by 30th April 2025.
• The PIC will oversee audit action plans supported by the Q&S team as an ongoing process and feature as a standing agenda during DC meetings to ensure continuous compliance (commenced).
• The provider has implimented monthly regional network team meetings to ensure oversight of quality and safety compliance across the DC (now in place).
• Completed: The provider has ensured the Quality and Safety team (Q&S) have designed a Schedule of Work. This includes a comprehensive review of the Statement of Purpose and all necessary documentation (bi-annually) required for registration. This will ensure that the application is ready for submission well in advance of the next registration period. This was completed on 6th March 2025.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The provider is committed to a full review of Schedule 5 policies this will be completed by the 30th of June 2025.
• Completed: The Medicines Management Policy has now been finalised and published. It provides specific guidance to staff on all aspects of medicines management and all the systems, processes and procedures related to management of medicines. It has been published in the organisations intranet and resource hub Gheel Resources and Services Portal.(GRASP). The whole staff team have been notified of the update and publication of the policy and it is explicitly shown at all training in relation to Medicines management. The associated nurse for the designated center is actively supporting staff to understand and implement all systems and procedures therein. This is done through SAM training, the day to day work of the DC dedicated nurse and through medicines being a standing item on team meeting agenda and the agendas of regional network meetings.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The PIC will ensure that there are sufficient staff trained in ISL for all residents who prefer to use sign language as their primary method of communication. Currently, two staff members are trained in this method and additional staff have volunteered to enroll

in training with a target completion date of (31st December 2025).
• Additionally, trained staff, supported by the SCM & AAP will collaborate with residents to create personalised videos and visual aids, enhancing communication support and making it more bespoke to each individual's needs to be completed by (31st May 2025).
• The provider is committed to a Total Communication Approach for all individuals in the designated centre., including Augmentative and Alternative Communication (AAC). From March 2025 AAC is now a fixed agenda item on both DC and regional support network meetings.
• This approach is guided by our external SLT and supported by the Advanced Autism Practitioner (AAP). The AAP has commenced (March 2025) providing specific training to ensure staff proficiency. The AAP is currently assessing the comminicative needs of each resident within the DC to offer guidance on specialist SLT services for assessment and staff training, to ensure optimal communication support for each person. Communication support will be documented and shared with the entire staff team through HTSM documentation, video, audio, and specialist apps using both high-tech and low-tech means. The project is ongoing, with significant progress underway to ensure comprehensive communication training and support.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The provider is committed to a full review of Schedule 5 policies. A full review of schedule 5 policies will be completed by the 30th of June 2025.
• The provider will ensure the development and implimention of a comprehensive Personal Finances and Possessions Policy. This policy will be finalised and communicated to all staff by 31st May 2025.
• PIC will ensure each resident will have a "How to Support Me" plan for understanding and managing their finances. This will complement FORM 4024 and any other relevant documents. These plans will be completed by (30 June 2025).

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The PIC and SCM are in the process of obtaining a grant for a refurbishment of the bathroom in Bungalow and the grant application has been sent in. works will commence by the end of 31st August 2025.
• The provider will upgrade the kitchen and fridge by (4th April 2025).
• The provider will complete minor upgrades to the staff bathrooms by (4th April 2025).

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• The regional network team will establish a schedule to review support plans. This schedule will commence in April 2025.

• A review of personal possesions and finance policy has begun and will be finalised by the end of 31st May 2025 to include all related support documentation.

• In the intereim PIC will ensure each resident will have a "How to Support Me" plan for understanding and managing their finances. This will complement FORM 4024 (Assessment of a person's knowledge and understanding for the safe management of their finances) and any other relevant documents. These plans will be completed by (31st May 2025).

• The PIC will ensure that there are sufficient staff trained in ISL for all residents who prefer to use sign language as their primary method of communication. Currently, two staff members are trained in this method and additional staff have volunteered to enroll in training with a target completion date of (31st December 2025).

• Additionally, trained staff, supported by the SCM & AAP will collaborate with residents to create personalised videos and visual aids, enhancing communication support and making it more bespoke to each individual's needs to be completed by (31st May 2025).

• The provider is committed to improving oversight mechanisms to ensure the safety and quality of care. All LM and SCM will now be included in Risk Register reviews every three months with the Q&S team and PIC. Additionally, risk registers will be maintained on the DC Intranet page to ensure they are easily accessible and up to date. This will help us proactively identify and address potential risks, ensuring a safer and more effectively monitored service. This will also be reviewed on a monthly basis during our regional network team meetings. The next review of the risk registers will be the 16th April 2025.

• The PIC has ensured the main pedestrian gate is now unlocked and provides access and egress through the pedestrian pathway and will ensure the main (vehicle access) gate to the DC will manually operate.

• The provider is committed to a full review of Schedule 5 policies. A full review of schedule 5 policies will be completed by the 30th of June 2025.

• The provider will ensure that the incident management process is reviewed and communicated to all local managers within DC to guarantee that all incidents are appropriately reviewed and closed within a suitable timeframe. Any learnings and trends of incidents will be discussed at team meetings, and relevant documentation will be updated. The PIC will ensure training for managers (by 1st April 2025) to ensure they are competent in downloading closed incidents, and uploading to each persons supported file on GRASP.

• The provider is committed to a full review of Schedule 5 policies to include reviewing and updating our incident management policy to ensure it is easily accessible to all management and to ensure consistency of the implementation and understanding. A full

review of schedule 5 policies will be completed by the 30th of June 2025. • The PIC, LM and SCM supported by Q&S will review and update all residents individual risk assessments to ensure they are comprehensive and detailed. This includes noting the use of any environmental practices and ensuring all risk assessments are risk-rated. This review will be completed by 31ST May 2025. Additionally the PIC and Q&S team will establish a process for regular review and maintenance of risk assessments to ensure they remain up to date and effective.

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 regional network team including the Q&S team and alongside the PIC and managers will establish a schedule for staff to review entire support plans, focusing on one section of person supported individual plan each month across the DC. This schedule will commence in April 2025.	

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	06/03/2025
Regulation 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/12/2026
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and	Not Compliant	Orange	30/06/2025

	retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/06/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2025
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	31/08/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively	Not Compliant	Orange	18/03/2026

	monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/06/2025
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.	Not Compliant	Orange	31/12/2025
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	31/12/2025
Regulation 04(2)	The registered	Not Compliant		31/12/2025

	provider shall make the written policies and procedures referred to in paragraph (1) available to staff.		Orange	
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	31/12/2025
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	31/12/2025
Regulation 05(6)(d)	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,	Substantially Compliant	Yellow	30/04/2025

	which review shall take into account changes in circumstances and new developments.			