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: | The Fairways |
| Name of provider: | Nua Healthcare Services Limited |
| Address of centre: | Offaly |
| Type of inspection: | Unannounced |
| Date of inspection: | 15 October 2025 |
| Centre ID: | OSV-0003389 |
| Fieldwork ID: | MON-0044940 |

## About the designated centre

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

The Fairways is a designated centre operated by Nua Healthcare Services Limited. The centre can provide residential care for up to seven residents, who are over the age of 18 years and who have an intellectual disability. This centre can also cater for the needs of residents who have mental health needs and specific behavioural support needs. The centre is located a short distance from a town in Co. Offaly. Each resident has their own en-suite bedroom and access to communal facilities that include kitchen and dining areas, sitting rooms, shared bathrooms, a sensory room and utility facilities. The facilities provided to two residents are within two self-contained apartments. There is a large enclosed garden to the rear of the centre that is accessible to residents. Staff are on duty both day and night to support the residents who live in the designated centre.

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

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| Number of residents on the date of inspection: | 6 |

## 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 |
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| Wednesday 15 October 2025 | 11:45hrs to 18:45hrs | Mary Moore | Lead |
| Thursday 16 October 2025 | 09:30hrs to 14:45hrs | Mary Moore | Lead |
| Wednesday 15 October 2025 | 11:45hrs to 18:45hrs | Maureen McMahon | Support |
| Thursday 16 October 2025 | 09:30hrs to 14:45hrs | Maureen McMahon | Support |

## What residents told us and what inspectors observed

This inspection was unannounced and was undertaken by the Health Information and Quality Authority (HIQA) to monitor the provider's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013. Inspectors found the provider had systems of governance and management in place that were responsive to what was a busy and complex service. While some minor documentation matters arose during the inspection overall inspectors were assured there was good and consistent oversight of the support and services provided to residents.

The designated centre is operated from a spacious two-storey house and a single storey house connected by a link corridor. Since the last HIQA inspection in January 2024 the provider had reduced the overall number of residents who could reside in the centre and some change had also occurred to the profile of the residents living in the centre. Three residents can be accommodated in the single storey property, two in their own self-contained apartments. Four residents can be accommodated in the main two-storey house.

Each resident had their own bedroom and bathroom and good provision was made in both houses for shared facilities such as communal and dining rooms and well-equipped kitchens. To promote resident privacy and safety there was a high level of interventions such as doors with coded access throughout the centre. The premises itself however was homely and welcoming with individual adaptations such as minimalist environments made within resident's personal areas. The centre is located on its own secure site a short drive from a busy town. Both apartments have access to a secure outdoor space. A spacious and pleasant rear garden is freely accessed to the rear of the main house. During this inspection six residents were availing of a residential service and there was one vacancy.

On arrival at the centre the inspectors were greeted by the person in charge. Generally, the inspection was facilitated by the person in charge, a shift lead manager and the director of operations. Inspectors also had opportunity during this two day inspection to meet and speak with other staff members including the second shift lead manager and to meet with all six residents.

All of the residents were welcoming and facilitative of the presence of the inspectors in their home. Engagement was largely led by inspectors with residents politely responding when spoken with. That engagement was sufficient however for inspectors to conclude that residents were comfortable in their home, with the management team and with the staff members on duty. The assessed needs of two residents did include communication differences and inspectors observed how they competently expressed themselves using manual signing, vocalisations and their general demeanour.

The assessed needs of the residents were diverse. Residents generally had their own routines. Challenges such as behaviour of concern and risk could and did arise. Over the course of this two day inspection inspectors noted that risks were managed so that each resident had good opportunity to be engaged, meaningfully occupied and to pursue particular interests including further education if they wished.

When the inspectors arrived at the centre one resident was getting ready to start an art therapy class and told the inspectors that they very much enjoyed this class. Two residents were preparing to go home to visit family with the support of staff. One of these residents was watching a programme on their mobile phone while they waited, smiled and gesticulated happily when inspectors asked if they were looking forward to going home. The second resident told inspectors that they enjoyed going home and mentioned a particular family member they were looking forward to seeing. Staff spoken with described the support provided to ensure that visits to home were enjoyable and safe. For example, staff described the management of the environment where there was an identified risk such as for the ingestion of inedible items. The arrangements for supporting visits were set out in resident's personal plans.

One resident was enjoying some gaming and had their own corner of a communal room set up for this. The resident welcomed the inspectors and exchanged pleasantries. Another resident greeted the inspectors and told inspectors that they were unsure as yet as to how they would like to spend their day. The resident expressed their preference that inspectors would not enter their personal space and this was respected.

The inspectors had the opportunity to see most other areas of the centre and found it was well maintained, designed and laid out to meet the needs of each resident. The provider had its own property maintenance personnel and an ongoing programme of maintenance.

In the context of the assessed needs of the residents and the overall occupancy of the service a high number of staff were on duty by day and by night. The provider frequently managed behaviour-related incidents. Residents required staff support and supervision to keep the resident themselves and others including peers and staff safe. Inspectors were advised that the provider had experienced some recent staffing challenges. Four staff had recently been recruited in response to vacated roles. Over the course of this inspection, inspectors saw that the staffing levels assessed as needed were in place including two-to-one staffing arrangements. Some staff on duty including the person in charge had established service in the centre and while it was at times a challenging service for staff to work in, these staff told the inspectors that they liked working in the centre.

There was a relaxed atmosphere in the service, staff were seen to provide the supervision that was needed while also giving residents some space. Staff were observed to freshly prepare meals for residents and one resident happily went with staff to assist with some grocery shopping. The resident said that the nearby town

was well served with a choice of different retailers. The resident told inspectors that they loved living in the centre and would be very sad if they ever had to leave.

Overall, inspectors found that the provider sought to achieve a reasonable balance between respecting resident's wishes and rights while also managing the high risks that could arise in the centre. Residents were spoken with about their care and support plans and staff sought to support residents to make better and safer decisions and to understand the risk mitigating controls that were needed for the safety of the resident and others.

In summary, inspectors found the provider maintained good oversight of the centre and had in place the arrangements needed to support residents and to ensure that residents were safe but also had a good quality of life. These arrangements included the comprehensive assessment of each resident's needs, plans for supporting those needs, good and consistent multi-disciplinary team (MDT) access and controls for mitigating risks. Some of those controls were not always consistent with what residents may have wanted or wished for, but the provider could demonstrate the controls were reasonable and proportionate to the risk that presented.

The inspection findings were satisfactory. Residents received an individualised service and the provider demonstrated a high level of compliance with the regulations reviewed. The person in charge, the shift lead manager and the director of operations were open to the inspection findings including where there was potential to further assure the quality and safety of the service. For example, by improving the guidance available for staff on matters such as the completion of a resident's personal laundry and the guidance for the use of both brand and generic medication names which was the practice in the centre.

The next two sections of this report will discuss the systems of governance and management in place in the designated centre and how these ensured the quality and safety of the service.

## Capacity and capability

Based on the findings of this inspection this centre was effectively managed and overseen. The management structure was clear as were individual roles and responsibilities. While staffing challenges had arisen the centre presented as adequately resourced. The provider was purposefully using the information it gathered about the service to ensure and assure the quality and safety of the service.

The day-to-day management and oversight of the centre was delegated to the person in charge. The person in charge had assistance from two shift lead managers. The person in charge had access as needed and reported very good support from their line manager the director of operations. Inspectors found all persons participating in the management of the centre had good and ready

knowledge of the general operation of the centre and the support needs of each resident.

The person in charge was based in the centre and was therefore actively present in the centre generally on a Monday to Friday basis. Inspectors noted that the person in charge was well known to the residents and exercised their role in leading and directed staff in a supportive way. In addition to this informal supervision the person in charge described the systems that were in place for inducting new staff members and for formally supervising staff members.

The staff duty rota was planned in advance and prepared by one of the shift lead managers. Given the staffing arrangements in this centre a large number of staff were needed with thirty-three staff listed on the staff duty rota seen by the inspectors.

All persons participating in the management of the service acknowledged that the provider had experienced some challenges in maintaining the staffing levels and arrangements assessed as needed by residents. The provider operated a minimum safe staffing level by day and by night. The provider had recently recruited additional staff who were in the process of completing induction and training and one of whom was due to commence working in the centre the week of this inspection. Over the two days of this inspection the staffing levels presented as adequate and where two staff were assessed as needed to support a resident, these staffing arrangements were also in place.

The inspectors reviewed the staff training matrix. Inspectors saw that mandatory and required training was complete such as in safeguarding, fire safety and responding to behaviour that challenged.

Formal systems of quality assurance included the completion of quality and safety reviews on an annual and at least six-monthly basis. An inspector read the reports of these reviews and saw that they were completed on schedule and the process included seeking feedback from residents and their representatives. During the most recent review completed in June 2025 the auditor had met with three residents. The person in charge had also actively sought feedback from resident's representatives. That feedback was recorded, was sufficient for it to be representative and was overall positive in relation to the support provided and the positive impact on residents. Where dissatisfaction was voiced there was good documentary evidence available to inspectors as to how this was addressed by the provider in consultation with other stakeholders as appropriate such as the Executive.

## Regulation 14: Persons in charge

The person in charge worked full-time. The person in charge had the qualifications, skills and experience required for the role. The person in charge understood and implemented the providers systems of management and oversight and, the requirements of the regulations. Based on these inspection findings the person in

charge was consistently engaged in the management and oversight of the designated centre.

Judgment: Compliant

## Regulation 15: Staffing

Inspectors found that the provider was effectively planning, managing and monitoring the adequacy of its staffing resources to meet the needs of the residents.

The management team confirmed that the provider had experienced staff recruitment challenges and operated a minimum safe staffing level that had to be adhered to. Inspectors saw that this minimum safe staffing level was set out in the designated centres contingency plan. Inspectors were advised that four staff had been successfully recruited, one recruitment was complete with the staff member due to commence working in the centre the week of this inspection. The person in charge confirmed there was capacity for existing staff members to work additional shifts so that residents had continuity of support.

Over the course of this two day inspection the observed staffing levels and arrangements presented as adequate to meet the assessed supervision and support needs of the residents. Specific staffing arrangements such as two-to-one staffing ratios were also noted to be in place. There was no evidence such as in incident reports seen that staffing deficits had contributed to increased risk and incidents that had occurred.

An inspector reviewed the planned and actual staff duty rota from the 1st September 2025 to the 5th October 2025. The rota was well maintained and showed each staff member on duty and the hours that they worked.

Nursing advice and support was available as needed from the providers own resources, for example, in relation to the management of prescribed medicines.

Judgment: Compliant

## Regulation 16: Training and staff development

Arrangements were in place for the supervision of staff and for ensuring the required training levels were maintained.

The person in charge described for inspectors the systems in place for the induction and supervision of all grades of staff. Staff completed a programme of centralised induction. The person in charge told inspectors that newly recruited staff had the

time to familiarise themselves with the complexities of the service and started work by supporting a resident with low support needs.

The person in charge confirmed that the frequency of formal staff supervisions could be increased if there was an identified need or concern. The person in charge confirmed that support and advice was available as needed from the human resource department in relation to any staff management or performance issues. Inspectors saw that the provider-led reviews monitored and ensured formal staff supervisions were taking place.

With regard to ensuring there were systems for the ongoing, informal supervision of staff, the person in charge was based in the centre as were the shift lead managers. The shift lead managers also worked some shifts as front-line staff members. This was evident from the staff duty rota.

An inspector reviewed the staff training matrix and saw there was a training record in place for each staff member listed on the staff duty rota. It was recorded that each staff member had completed the centralised induction programme and mandatory training including training in safeguarding residents from abuse, fire safety, manual handling and training in re-escalation and intervention techniques in response to behaviour of concern. The date that refresher training was due to be completed was highlighted so that it would be booked.

Additional training completed by staff reflected the assessed needs of residents and included training in augmentative communication methods.

A shift lead manager spoken with had ready knowledge of staff training requirements including the recent completion of on-line children's safeguarding training.

The provider supported staff to complete further training and professional development. Both shift-lead managers told inspectors they were undertaking further social care studies and were supported by the provider to do this.

Judgment: Compliant

## Regulation 23: Governance and management

Based on these inspection findings the designated centre was effectively governed, managed and overseen. The provider demonstrated a high level of compliance with the regulations reviewed on this inspection and was open to the verbal feedback of these inspection findings.

Inspectors found good clarity and continuity in the local management arrangements. For example, the shift lead managers understood their role and their duties and

could clearly describe these to the inspectors. It was evident that the residents and the staff team knew who the person in charge was.

The provider had systems that maintained oversight of the effectiveness of these local management systems. For example, the director of operations was very familiar with the general operation of the centre, any matters arising and how these were responded to. Systems of quality assurance included ongoing discussion with residents and their representatives, liaison with the designated safeguarding officer, the wider MDT and the Executive. Good oversight was maintained of incidents that occurred.

The provider had completed the annual quality and safety review and the quality and safety reviews to be completed at least every six-months. The reports of these reviews were available to the inspectors. Inspectors saw that these reviews sought feedback from residents and their representatives. Persons responsible for the progress of the quality improvement plan were clearly identified and completion timeframes were specified. The most recent internal provider-led review had found an improved level of compliance in the centre and that would concur with these satisfactory HIQA inspection findings.

The centre presented as adequately resourced. Residents were provided with a safe and comfortable home and the provider continued to recruit staff so as to maintain the staffing levels assessed as needed.

Judgment: Compliant

## Regulation 31: Notification of incidents

The provider had systems in place for ensuring the Chief Inspector of Social Services was notified of prescribed incidents and events. For example, inspectors saw that the providers incident report system triggered any notification requirement and provider-led audits reviewed the incidents that had occurred and ensured notifications had been submitted as required. For example, in relation to the use of restrictions.

Judgment: Compliant

## Quality and safety

Based on the findings of this inspection, the provider demonstrated a high level of compliance with the regulations relating to the quality and safety of care delivered to residents. Residents in this centre had highly specific assessed needs and required staff support in areas such as safeguarding, behavioural management,

nutrition and communication. Inspectors found arrangements appropriate to these assessed needs were in place.

Inspectors discussed the care and support needs of all residents and reviewed in detail two residents personal plans. Inspectors saw that a comprehensive assessment of needs had been completed and the information gathered by the assessment informed the development of the personal plan. Residents were spoken with in relation to their care and support needs generally through the format of key-working meetings. There was good documentary evidence that plans of support and care were informed and advised by the wider MDT. For example, in relation to behavioural management.

The comprehensive assessment of needs included a healthcare assessment. Inspectors saw that where there was an identified healthcare need there was an associated plan of care. Residents had good access the the providers MDT, were supported by staff to attend clinical reviews and to attend their own General Practitioner (GP).

Inspectors observed practice, discussed and reviewed records relating to resident's nutritional needs. Inspectors found that different arrangements were in place for different residents based on their assessed needs and the advice and recommendations made by the MDT. A resident spoken with told an inspector they were very satisfied with the quality of the food and commented that the food was 'amazing'.

An inspector reviewed how medicines were managed in the designated centre. The provider had appropriate systems in place in relation to the prescription, supply, storage and administration of medicines including medicines that had enhanced management controls.

Inspectors found the provider was proactive in the promotion of safeguarding residents. Where concerns were identified the provider had referred these to the safeguarding team for screening, input and oversight. The designated safeguarding officer was available to the centre as and when required. This was clearly evidenced in records provided to inspectors and specific matters discussed with the management team.

The assessed needs of residents included behaviour of concern that posed a risk to the resident themselves and others including peers and the staff team. The range of behaviours that could present was broad as was the risk that presented and the seriousness of the impact of the behaviour. The staff team frequently managed behaviour-related incidents. Inspectors saw that comprehensive multi-element behaviour support plans were in place. These were devised by the positive behaviour support team. Residents had access to a range of MDT supports including behaviour support, psychiatry and psychology.

While the approach to the prevention and management of behaviour was therapeutic a number of interventions were in use that met the definition of a restrictive practice including restrictions on residents rights. While the provider strived to respect resident choice and autonomy there was clear risk based

documentary evidence as to why residents could not always do what it was they wanted to do given the significant potential for risk and harm to the resident and to others. Residents were spoken with about these restrictions, why they were needed and had opportunity to discuss and gain insight into the behaviour and its impact.

In the context of the risks that were managed in this centre inspectors were assured that controls to mitigate the risk were reasonable and proportionate to the risk that presented. Good oversight was maintained of incidents that did occur and there was evidence of responsive actions such as re-referral to the MDT and feedback to staff.

While managing risk the provider did strive to adopt a positive risk taking approach. Residents received individualised care and support and enjoyed activities and lifestyles largely of their choosing as long as it was safe. There was flexibility in the provision of this service. Some residents accessed day supports outside of the centre. One resident told an inspector that they attend the provider's continuous learning and development (CLaD) hubs in a nearby town. Residents attended educational facilities and engaged in voluntary work in the local community.

The provider ensured that residents were supported to communicate in line with their assessed needs. An inspector saw a resident and staff members competently use Lámh to discuss a choice of activity. Staff spoken with demonstrated good knowledge of the communication supports and strategies outlined in residents' communication profiles.

Residents were provided with a safe and comfortable home. The accommodation provided was suited to the needs of the residents and was well maintained. Some areas were minimalist in design and presentation in line with the needs of individual residents and identified risks. However, inspectors saw that the majority of residents had access, supervised for some residents, to shared areas of the centre such as the comfortable communal rooms and the kitchens.

There was visual and documentary evidence of good fire safety management systems. These systems included the arrangements for evacuating residents and staff from the centre in the event of an emergency such as a fire emergency.

## Regulation 10: Communication

Residents had different communication needs. The provider had arrangements in place that ensured residents were supported and assisted to communicate in accordance with their needs and wishes.

Inspectors reviewed a sample of two personal plans and saw that the plans included guidance for staff on how to communicate effectively with the resident. One resident's communication records reflected the use of a total communication approach. A combination of communication methods were used with and by the

resident such as the manual signing observed by inspectors, pictures and physical guiding of staff.

Residents had support from the MDT including speech and language therapists to help with their communication needs and staff had completed training in the resident's preferred communication method.

In general, inspectors saw that residents had access to a range of media and personal devices and were provided with information on local upcoming events that they could choose to attend if they wished.

Judgment: Compliant

## Regulation 11: Visits

The provider had visiting arrangements in place. These arrangements were specific to each resident and were outlined in the personal plan. The inspectors saw during the course of this inspection that residents were supported by staff to visit home and family. Staff spoken with described the arrangements in place for supporting visits in the centre and outside of the centre. This included any specific requirements or arrangements that were in place to manage risk so as to ensure the safety of these visits.

Judgment: Compliant

## Regulation 12: Personal possessions

Residents were supported, as far as reasonably practicable, to keep control of their own possessions and to manage their own finances.

Some residents managed their own finances whilst others required support from staff. Where residents required supports there was a documented rationale for this such as a residents limited ability to balance their income with their expenditure.

An inspector saw that where staff provided support clear records were maintained of all transactions. The inspector reviewed the financial records for 2025 for a resident. Receipts were in place for expenditures such as activities, treats and a take-away that the resident liked to have weekly and that the resident had chosen.

Each resident had a clear record of their belongings recorded and this record was actively maintained in the centre. Where there was a requirement to support residents to manage their personal belongings, detailed plans were in place setting out how this was done in consultation with residents.

One resident did not have access to or control over their personal monies. Inspectors were advised that the resident had limited funds despite the fact that they were in receipt of a disability allowance. Inspectors found that the management team were very aware of the impact of this on the resident and ensured the resident had sufficient comforts. Inspectors were provided with clear documentary evidence that the provider had advocated to support the resident to gain access to their personal monies. Measures the provider had taken to support this resident to gain financial control of their monies included referral to the National Advocacy Service, to an Garda Síochána and the National Safeguarding team amongst others. This process was ongoing during this inspection with further actions planned by the provider. However, despite the efforts of the provider this matter was not resolved.

Judgment: Substantially compliant

## Regulation 13: General welfare and development

Inspectors saw that the evidence base of the care and support provided to residents was informed by the comprehensive assessment of needs and ongoing input from the multi-disciplinary team. The opportunities that residents had to be meaningfully engaged and occupied was broad and informed by specific needs, abilities, interests and risk. Inspectors saw and read that residents had access to and availed of a range of programmes in the centre and in the community such as art therapy, further education, skills-teaching, swimming, sports with organisations such as the special Olympics and different social events such as an upcoming Halloween party organised by the provider.

Judgment: Compliant

## Regulation 17: Premises

The design and layout of the centre met the aims and objectives of the service and was suited to the needs of the residents. Different arrangements were in place for different residents based on their assessed needs.

During their walk around of the centre, inspectors saw that the centre was spacious, well-maintained, visibly clean and nicely furnished. All residents had their own bedrooms and bathrooms. There was adequate provision for residents to store their clothing and personal belongings. Where different arrangements were in place the person in charge could explain the rationale for these such as a resident's sensory needs or an identified risk for the ingestion of unsafe items. Keypad access to

mange risk and to protect resident private space was maintained between the two main areas of the centre and throughout each area.

Inspectors saw plans developed and implemented in consultation with residents for supporting residents to manage their personal space. One resident discussed with inspectors how they used an external shed provided to them to store some excess items and was very happy with this arrangement.

Both main areas of the centre had well-equipped kitchens.

Laundry facilities were available that residents could access and use if they wished and with staff supervision as appropriate.

Residents had access to secure outdoor space and a well-kept rear garden. Residents also had access to swings, trampolines and garden furniture based on their individual preferences.

The centre had a sensory room with equipment such as lights and tactile surfaces. This project was supported by a recognised society for autism in its design.

The centre was equipped with Wi-Fi, televisions, and gaming consoles for residents' use where appropriate.

The provider had an ongoing programme of property maintenance and improvement. For example, inspectors noted some new plumbing infrastructure. The person in charge confirmed that this was recently completed to improve the quality of the hot water.

Judgment: Compliant

## Regulation 18: Food and nutrition

The food and nutrition arrangements in place were consistent with each resident's individual dietary needs and preferences. Overall, inspectors were assured resident's nutritional needs were well met.

The centre had two well-equipped kitchens one in each part of the centre where food could be stored and prepared in hygienic conditions. Inspectors saw a range of fresh, dry, refrigerated and frozen food products. A resident told an inspector they went food shopping with staff as they wished and this was observed by an inspector on the day of inspection.

Residents assessed as requiring modified diets and meal plans had access to speech and language therapy and staff spoken with were aware of the required modifications. As residents had different routines, were at home, at a day service or out at activities during the day, inspectors did not have the opportunity to observe

structured meal times. However, inspectors saw staff to prepare meals and noted an evening meal that appeared wholesome and nutritious.

An inspector reviewed and discussed the nutritional plan of a resident with specific dietary and nutritional support needs. The resident received appropriate support. The residents nutritional plan was supported by a dietitian and the positive behaviour support team. The plan addressed the management of food intake and overall health needs. Guidance was available for staff to ensure consistency in supporting the resident. This included plans so that the resident had access to suitable snacks while supporting the resident to manage any anxiety related to food. Staff spoken with described for inspectors how these plans were implemented.

Inspectors saw that staff maintained good records of the meals, snacks and refreshments provided to residents. The records reflected good choice and variety. At verbal feedback of these inspection findings inspectors did discuss how these records, while good, could be improved further. For example, including details of portion size particularly where there were specific concerns and plans in relation to food intake.

Judgment: Compliant

## Regulation 26: Risk management procedures

Appropriate arrangements were in place for the identification, management and ongoing review of risk. Based on the evidence available to inspectors the providers system for reporting incidents, reviewing incidents and their management was used as intended by the provider so as to ensure the safety of residents and staff.

The inspectors reviewed two residents individual risk management plans and the reports of two specific high risk incidents that had occurred. The inspectors discussed the particular incidents, discussed how risk in general was managed and how mitigating controls were agreed and reconciled with resident's expressed wishes and preferences. Inspectors found there was justification for the controls in place, clarity and good consistency between the records seen and staff spoken with.

In the incident reports seen staff had recorded in detail what had happened, why it might have happened and how staff responded including the use of any safety intervention. While risks were identified there was an unpredictability as to how that risk might present meaning that staff had to be vigilant and adhere to the prescribed plans. Inspectors saw that management had reviewed these incidents and addressed with staff any issues that did arise.

Residents were spoken with in relation to incidents that had occurred and the risk mitigating controls that were in place.

Overall, based on the observations of this inspection inspectors were satisfied the measures in place were proportionate to the risks identified and supported residents

to safely have a good quality of life. The provider was open to and consistently monitored the potential to reduce control measures.

Judgment: Compliant

## Regulation 28: Fire precautions

Fire safety management systems were in place.

Inspectors saw that emergency lighting, a fire detection and alarm system, fire-fighting equipment and fire-resistant doors with self-closing devices were all in place. There was documentary evidence that staff completed fire safety checks and external competent persons completed quarterly inspections and tests.

Manual call points were in place and escape routes were signposted and unobstructed. Where some manual call-points were key-operated staff spoken with could describe their operation. Staff understood that the coded access doors released once the fire alarm was activated. Inspectors used a number of these doors over the course of this two-day inspection and noted that the doors closed shut. Proprietary devices were provided for holding the doors open if required.

Each resident had a personal emergency evacuation plan (PEEP) that outlined each residents understanding of the evacuation procedure and any guidance and support the resident might need to safely evacuate. Staff said and one PEEP clearly outlined that a resident may decline to evacuate during simulated evacuation. The provider was satisfied that the resident had a good understanding of the importance of evacuating in the event of fire but a plan was in place for staff to follow in the unlikely event that the resident would not evacuate for them.

Staff and residents did participate in regular evacuation drills. The inspector reviewed the reports of the six drills completed to date in 2025 and saw that different staff had participated in these drills, the drills were scheduled at different times such as late at night and following a recent admission. All residents had co-operated with the request to evacuate and left the house in a timely manner.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The provider had good systems in place for the management of medicines. The provider had a policy and procedures governing the management of medicines. An inspector saw that practice such as for the transcribing of medicines was in line with that policy.

An inspector saw that medicines were supplied by a community based pharmacist and were securely stored in the centre. Inspectors reviewed a sample of three residents medicines records. The records contained all of the required information such as the residents name, each medicine prescribed for the resident, the dosage and the time the medicines were to be administered. It was noted however that some records included both the generic and trade names of medicines, while others did not. Inspectors found no evidence that this had contributed to medicine related incidents in the centre. Inspectors were provided with further guidance available to staff in the centre on the use of interchangeable names. Based on the observations of this inspection there was scope to improve the guidance available for staff so as to easily identify, reconcile and confirm the accuracy of the medicines and the stock supplied. This was discussed at the verbal feedback of these inspection findings.

An inspector reviewed the providers records of medicines related incidents that had occurred in the centre in quarter three 2025. These records indicated documentation errors with no serious incidents having occurred. The director of operations discussed with both inspectors how medicines related incidents were reviewed to identify any failings in the medicines management process and any learning required. The provider had taken steps to address medicines related errors by providing additional training for staff where required and the use of a reflective model to support staff learning and development.

The inspector saw that where medicines were prescribed as an adjunct to the multi-element behaviour support plan, a detailed protocol was available to guide staff in the administration of this medicine.

Risk, resident capacity and interest in the management of their own medicines was considered as part of the comprehensive assessment of needs.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

The provider had completed a comprehensive assessment of residents' health, personal and social care needs. The assessment and the personal plan put in place after the assessment was reviewed and updated on a regular basis.

The inspectors reviewed the records of two residents. Comprehensive assessments had been completed within the previous 12 months. Based on the findings of the assessment, plans of care and support were put in place to guide staff on how to support the residents. Inspectors found these care plans were regularly reviewed and kept up to date.

Daily notes were kept on each resident with information about the activities they were involved in, as well as notes in relation to health and well-being. The daily notes seen by inspectors reflected the guidance of the personal plan such as the

monitoring of nutritional and fluid intake and a residents compliance with their multi-element behaviour support plan.

Residents' personal goals had been agreed at annual planning meetings and progress in achieving these goals was reviewed and updated. For example, a resident was progressing learning to cycle and had plans to visit a local scenic area in the coming weeks to progress this skill.

Judgment: Compliant

## Regulation 6: Health care

There was good documentary evidence that residents were receiving appropriate healthcare with regard to each residents assessed needs and personal plan.

Healthcare plans reviewed by inspectors supported that residents had good access to health and social care services to support them to experience good health. For example, there was evidence of collaboration with general practitioner (GP) services. Records seen confirmed residents attended their GP for regular health check-ups and other treatments as required such as blood tests.

Residents had access to a range of clinicians including psychiatry, psychology, occupational therapy, speech and language therapy, dentistry and a dietitian. Support was tailored to individual assessed needs. For example, staff described how one resident was supported to attend a specific dental practice that was better suited to their assessed sensory related needs.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Arrangements were in place to support residents to manage behaviour of concern and to guide staff on the prevention and response to those behaviours. Good oversight was maintained of interventions that met the benchmark of a restrictive practice.

The two multi-element behaviour support plans seen by inspectors reflected the diversity of residents behavioural support needs, the behaviours described by staff and reflected the behaviour management strategies seen by inspectors such as the management of residents personal belongings and the staffing levels and arrangements in place. The plans were devised and kept under review by the positive behaviour support team. Records seen confirmed that residents also had access as needed to psychiatry and psychology.

A number of restrictive practices to keep residents, peers, staff and others safe were in use. The multi-element behaviour support plan and the individual risk management plan set out the rationale for their use including the sanctioned use by staff of safety interventions. Records were maintained of their use and they were subject to on-going multidisciplinary input and review. Their use was discussed with residents.

Where it was reasonable and safe to do so the provider was striving to reduce restrictive practices and to ensure they were only implemented as a last resort, and in response to a safety or safeguarding concern. For example, records seen showed that the provider was tracking the use of a restrictive practice in a service vehicle with the intention of reducing its use. An inspector also requested and reviewed an incident where staff had used a safety intervention. Staff had recorded the intervention used, how long it was used for and why it was used. The inspector was satisfied it was used as prescribed in the plan as a last resort and to prevent further imminent injury to a staff member.

Judgment: Compliant

## Regulation 8: Protection

The provider had arrangements in place for safeguarding residents from harm and abuse. Based on what inspectors discussed and read safeguarding was consistently integrated into the support provided to residents.

Safeguarding arrangements were in place and these differed dependent on the needs and circumstances of each resident. Inspectors saw that safeguarding was included in the comprehensive assessments of needs. Safeguarding risks were identified and safeguarding plans were put in place based on the findings of the assessment.

Records seen confirmed that safeguarding was discussed with residents as the provider sought to establish resident understanding and insight of safeguarding matters. Safeguarding material was also on display in the centre.

Referrals was made to the designated safeguarding who actively inputted into the management of safeguarding matters arising in the centre. The provider also notified other relevant parties such as the local safeguarding and protection team and an Garda Síochána. The provider notified the Chief Inspector of Social Services of any alleged or suspected abuse.

Staff had completed training in the safeguarding of adults and children from abuse. Staff spoken with were knowledgeable on their responsibilities to report and respond to any safeguarding concerns.

Judgment: Compliant

## Regulation 9: Residents' rights

There was a strong focus on respecting and promoting residents rights. This could be challenging at times in this centre as the provider sought to achieve an agreeable balance between managing significant risk and supporting resident choice and preference.

Inspectors found an individualised approach to the planning and delivery of the care and support provided to residents. This meant that while the provider respected the individuality of each resident and listened to their expressed wishes and preferences, there were at times, limitations to the degree to which residents could act on their own preferences and decisions. For example, residents were spoken with and had opportunity to discuss incidents that had occurred but did not always demonstrate learning or an understanding of the impact on others. This meant that if there were restrictions on what residents wanted to do the restrictions remained in place.

Residents were spoken to about their rights but also the providers duty of care to the resident and others. There was evidence of balance and proportionality. For example, if residents wanted personal space and privacy without a staff presence they could have it but not in shared communal spaces.

Residents' religious and civil rights and preferences were established and respected. For example, if they wished to practice religion or not and these choices were supported.

Capacity assessments had been carried out for medication and financial management and these were being managed accordingly. If a resident changed their mind this was respected. For example, the person in charge described how a resident had found managing their own medications had increased their overall level of anxiety rather than giving them a sense of independence and control.

The provider advocated for the rights of residents and ensured that residents had access to and the support of advocacy services. For example, as discussed in relation to the efforts made to gain control for a resident of their personal finances.

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** | |
| 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 11: Visits | Compliant |
| Regulation 12: Personal possessions | Substantially compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | 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 The Fairways OSV-0003389

## Inspection ID: MON-0044940

## Date of inspection: 16/10/2025

**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** |
|---|---|
| Regulation 12: Personal possessions | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 12: Personal possessions:<br>1. The Person in Charge with support from the Individual's funding HSE representatives will continue with their efforts to support the Individual to obtain financial control of their monies until a resolution is reached.<br><br>Due Date: 31 December 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 |
|---|---|---|---|---|
| Regulation 12(1) | The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs. | Substantially Compliant | Yellow | 31/12/2025 |