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:	Short Notice Announced
Date of inspection:	01 February 2024
Centre ID:	OSV-0005301
Fieldwork ID:	MON-0040742

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 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:	17

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 1 February 2024	09:55hrs to 17:00hrs	Jennifer Deasy	Lead
Thursday 1 February 2024	09:55hrs to 17:00hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

This inspection was carried out to monitor ongoing regulatory compliance in the designated centre. The inspection was short-notice announced due to the assessed needs of the residents and was completed by two inspectors due to varied layout of the centre across multiple buildings, building types and locations.

Inspectors visited all parts of the designated centre and had the opportunity to meet with and talk to residents and staff. The inspectors used the walk-around of the premises, conversations with residents and staff, as well as a review of documentation to inform judgments on the quality and safety of care of the service.

Overall, the inspectors saw that the staff were endeavouring to provide person-centred care and that the provider had made progress in addressing many of the premises issues highlighted in the last inspection of the centre. However, the inspectors saw that the premises continued to require considerable upkeep and that there were serious risks in relation to fire containment and the safe evacuation of residents which had not been identified, or controlled for, by the provider.

This centre was comprised of multiple housing units, most of which were located on the provider's campus. On campus, there were three group houses and five single occupancy apartments. The provider had also recently added a newly-built, off-campus, single-occupancy house to the footprint of the centre. This had been registered and was occupied by the time of the current inspection.

The inspectors saw that, for the most part, the single occupancy apartments and the single occupancy house were well-maintained and were offering good quality, individualised care and support. Some upkeep was required to the on-campus apartment bathrooms however, the provider was aware of this and had plans to complete the required maintenance. The group houses required more substantial upkeep. This will be discussed further in the quality and safety section of the report.

Each of the housing units had a designated location manager who reported to the person in charge. Inspectors had the opportunity to meet the location managers in each house and to discuss the care and support provided. Location managers were informed regarding residents' assessed needs and preferences. The inspectors were told that many residents enjoyed working in paid employment, attending day services, accessing the community and visiting family. Some residents had chosen to complete preferred activities from their home on the day and the inspectors saw that there were sufficient staff to support these residents in line with their assessed needs.

The inspectors saw that the newly registered off-campus house was providing particularly good quality care and support. One resident had moved from the provider's campus into this house. The location manager said that the move had been positive for them, for example, there was a significant reduction in the use of

restrictive practices and the resident was engaged more with their community.

Inspectors met and spoke to many of the residents, some of whom communicated about their hobbies, interests and their perspectives on the care and support in the centre. Residents spoke positively about their home and the staff support. Residents showed inspectors their pets and how their personal items were stored or displayed carefully in line with their preferences. One resident said they wanted to move to a community-based home. They were being supported by the provider with this goal. Some residents communicated through non-verbal means. Inspectors were assisted by staff to engage with these residents.

The inspectors saw, while walking around the centre that there was visual information on safeguarding, infection prevention and control, Assisted Decision-Making (Capacity) Act 2015, independent advocacy services, and complaints. Some residents used visual aids to help them plan their meals and activities. Staff were observed engaging kindly and respectfully with residents, and residents appeared to be comfortable with staff presence. Residents moved freely around their home and appeared comfortable and relaxed.

In the three group houses the inspectors observed that the provider had completed a considerable amount of refurbishment works subsequent to the last inspection. Some of the works including installing new flooring, a new ceiling, new kitchens, utility and bathroom refurbishments as well as purchasing new furniture. Staff told the inspector about the positive impact that this was having on the lives of the residents, for example, one house had been fitted with an accessible bath which enabled residents to have a bath in line with their preferences. Staff informed the inspectors that residents enjoyed the bath and that it enhanced the quality of care. There remained works required to aspects of the premises including, for example, further bathroom refurbishments and works to the exterior of the houses. This will will be described further in the quality and safety section of the report.

The inspectors saw that there were some restrictive practices in the group houses which had not been recorded as such. For example, there were bells on entrance and exit doors to some houses. Staff were informed regarding the rationale for these bells and told the inspector that they were required to control for specific risks. However, the staff and the person in charge acknowledged that they had not been identified as restrictive practices and were not recorded on the centre's restrictive practices register.

Across all of the group houses, the inspectors saw that there were risks with fire containment and evacuation. There was an absence of door closers from bedroom doors and some door closers, where fitted, were broken. Additionally some fire doors were damaged and would not be effective to contain smoke or fire. Not all emergency exit doors were thumb locked which could potentially impede a safe evacuation of the residents. An immediate action was issued by inspectors in respect of one of the group house's fire containment measures. This will be discussed further in the next two sections of the report.

Overall, the inspectors saw that residents were comfortable in their homes and that

they were supported by familiar staff. The provider and staff team were endeavouring to provide person-centred care and support. However, there were improvements required to the oversight arrangements and, in particular, the oversight of risk, to ensure that this care was provided in a safe environment.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspectors found that, while there were clear reporting structures in place, these were not effective in ensuring that the service was consistently monitored and was safe.

The oversight arrangements required improvement to ensure that all staff were informed of their roles and responsibilities and to ensure that risks were identified and responded to in a timely manner. Additionally, the provider's audits required enhancement to ensure that they comprehensively identified risk, put timely action plans in place and were effective in driving service improvement.

A full review of the oversight arrangements was required. While there were local managers in each location who reported to the person in charge, the inspectors were not assured that the roles and responsibilities of these stakeholders were adequately defined or that they were effective in supporting the person in charge to have oversight of the risks presenting to the safe delivery of care.

There were a number of risks identified which were not known to the person in charge or to the provider. For example, in one group house, the inspectors saw fire retardant glass in a fire door was missing. Staff and the location manager told the inspector that this had broken some time ago however, there was a lack of documentation regarding the incident that had led to it becoming broken and the inspector could not see that the person in charge or provider had been made aware of the damaged door. It was not established who had the responsibility for recording damage to the property and for risk assessing this damage and putting in place actions to address the issue. This was resulting in a fire and smoke containment risk in the centre.

In addition, the provider's audits were not effective in identifying risk and in driving service improvement. For example, a six monthly audit had been completed in December 2023 which had not identified the numerous fire containment and evacuation risks. The inspectors saw that many fire doors were damaged, there was an absence of thumb-lock mechanisms on fire exit doors and some bedroom doors did not have door closers, or in one instance, a bedroom door closer was damaged

and not effective. Due to the failure to identify these on audits, there was no time-bound plan in place to address the fire deficits and there was no risk assessment implemented to control for risks in the interim.

The provider's audits did not consistently track progress on action plans across audits. For example, a six-monthly audit completed in August 2023 set out that two full bathroom refurbishments were required in one of the group houses. One bathroom had been refurbished subsequent to that audit. However, a second audit completed in December 2023 did not set out that the other bathroom remained outstanding for refurbishment works.

The impact of this was that there were a number of risks to the quality and safety of care for the residents. The inspectors were sufficiently concerned regarding the risk presented by the fire containment measures in one of the houses that an immediate action was issued. The provider was required to take action to contain for fire on the day of inspection. The provider demonstrated that this was completed before the inspectors left. This will be discussed further in the quality and safety section of the report.

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge who was employed in a full-time capacity. They had worked in a management role previously in this designated centre and knew the residents and their needs well. The person in charge reported to a director of operations and had regular meetings with the provider.

The designated centre was large in size and consisted of multiple housing units, resulting in the person in charge having a large remit. Each of the units supported residents with varying needs, ages and levels of support required. The provider had nominated location managers to support the person in charge in having oversight of the designated centre. However, this inspection found that the oversight arrangements were not wholly effective in ensuring the safety of the service. This required review by the provider.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had failed to ensure that appropriate systems were in place to effectively monitor and oversee the quality and safety of service provided in the centre which posed a risk to residents' safety and wellbeing.

The designated centre had a clearly defined reporting structure. Each house was

allocated a location manager who reported to the person in charge. The location managers managed the centre on a day-to-day basis and told the inspectors that their duties included providing staff supervision and overseeing support plans. The person in charge then reported to a director of operations.

However, the roles and responsibilities of each of the stakeholders in the management system were not clearly defined. Location managers, and staff, were not suitably informed regarding their roles and responsibilities in identifying risk and the pathways through which to escalate serious risk to the provider level. This was compounded by the provider's audits which were ineffective in identifying risk and in driving service improvement.

For example, in one house, inspectors saw that there were numerous fire risks including fire doors held open with furniture, damaged fire doors and emergency exit doors which were locked with keys. The inspector asked staff about one fire door which was missing a pane of glass. Staff told the inspector that this had broken some time ago when the door was closed forcibly. Staff were unsure if this had been recorded as an incident or escalated through the reporting structure to the person in charge and the provider. While staff were unsure of the exact time as to when this incident had occurred, they reported that it was possibly in November 2023. The provider had completed a six-monthly audit of the quality and safety of care in December 2023. This audit failed to identify the risk presented by this fire door along with numerous other fire risks seen on the day of inspection.

The provider's response to audit findings required more consideration, for example, the unannounced visit report carried out in August 2023 noted that some premises issues required immediate attention, however inspectors found that some of the issues remained outstanding. These issues had not been identified on the subsequent provider audit completed in December 2023. This audit failed to set out actions which had not been progressed subsequent to the last audit, for example outstanding bathroom refurbishment works.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. Overall, inspectors found that staff were endeavouring to provide person-centred care however there were a number of risks to the safety and well being of the residents. In particular, there were improvements required to the fire containment and evacuation measures, and to ensure that the premises was homely and well-maintained.

The designated centre was comprised of multiple housing units which included individual apartments and group houses. The inspectors were told that it was the provider's intention to move towards more individualised living for the residents of

this designated centre however there was no time-bound plan in this regard. A recent move of one resident to an independent living arrangement had resulted in the elimination of several restrictive practices which had been impacting on other residents. The provider recognised this as a positive achievement for all of the residents involved and as upholding their human rights.

There were however a number of risks identified on this inspection. Many of the housing units continued to require premises works. The premises of some of the units were impacting on the quality and safety of care for the residents. For example, some of the houses continued to require upkeep to ensure that they could be effectively cleaned. Additionally, due to the location of some of the houses and the way in which the surrounding grounds were used, there was at times an institutional aesthetic observed.

In particular, the inspectors were concerned regarding the management of risk, especially the risk presented by fire. There were numerous issues with fire containment and fire evacuation identified across many of the housing units. The inspectors were not assured that the provider had adequately controlled for these risks. The provider's audits had not identified these risks and they had not been escalated through the management system to the provider level.

An immediate action was issued in relation to fire containment in one of the houses. The provider was asked to close fire doors which were wedged open by furniture in order to assist in containing fire and smoke in the event of a fire. This was completed by the staff on the day of inspection. However, there remained a number of fire risks which required a comprehensive review.

Regulation 11: Visits

The provider had ensured that there were appropriate facilities such as private areas for residents to receive visitors. Some residents told inspectors that they enjoyed visits from their family and that there was no restriction on receiving visitors.

Staff told the inspectors that some residents chose to have family members meet them in their bedrooms where they felt comfortable, while other residents chose to meet with family in the sitting rooms.

Judgment: Compliant

Regulation 17: Premises

The centre accommodated 17 residents across five self-contained apartments and three houses located on a campus setting operated by the provider; and a community based house located close to the campus. Since the previous inspection

of the centre in June 2023, renovation works had been carried out to many houses, such as installing new kitchens, utility room units, flooring and purchasing of new blinds and furniture. However, inspectors found that parts of the premises were in a poor state of repair, requiring upkeep and renovation to mitigate infection prevention and control hazards and to ensure that the centre was homely and well maintained. Only the recently built single-occupancy house located off-campus did not require any upkeep. Examples of areas of the premises requiring attention, as observed by the inspectors, are detailed below:

- Some bathroom facilities required renovation, for example, flooring was stained, there was mildew on a wall, tiles required regrouting, and equipment used by residents was rusty.
- Some bathrooms and shower rooms were not laid out or decorated to be inviting spaces to use, for example, they were very small and did not contain items such as mirrors or facilities for residents' personal toiletries when using the bathroom.
- There was a strong malodour in one apartment and shower room.
- Walls in a utility room and bedroom were damaged.
- Some kitchen units were worn, for example, the veneer was damaged and had detached in places.
- The outdoor space required tidying, for example, there was a rusty bistro table and chairs, and broken glass on the ground where glass jars were stored.
- The door to an outdoor storage unit had fully detached and had not been repaired.
- In one location, there was a build up of moss on the roof and the porch covering was rotten in places.
- The main grounds presented an institutional aesthetic, for example, there was unused items such as a dishwasher, damaged chairs, and a broken kitchen appliance observed on the grounds, as well as a large skip close to the entrance of one home.

The provider had also failed to provide suitable equipment for residents in line with their needs. For example, the sanitary ware in one bathroom was not appropriate to the resident's needs and was having a negative impact on their experience of living in the apartment. While the provider told inspectors that they had plans to renovate the bathroom, there was no confirmed time frame for these works to be completed.

Judgment: Not compliant

Regulation 26: Risk management procedures

Inspectors found that the provider's arrangements for monitoring risk control measures required improvement. It was not demonstrated that control measures to reduce risks and mitigate hazards were effectively monitored. Inspectors observed that measures to reduce fire and infection risks were not being implemented

effectively and the provider had failed to self-identify these issues.

Inspectors were also not assured that certain control measures had been properly assessed to ensure that they were proportionate to the risk concerned. For example, the use of some environmental restrictions had not been subject to risk assessment. These restrictions included a keypad lock which had potential to impact on the fire evacuation arrangements and bells on exit doors in some of the houses, to alert staff to when residents were leaving the house.

Other risks were identified by the inspectors which had been observed by staff but had not been escalated to the provider, either through the management systems or through the provider audits. For example, inspectors saw that fire doors were damaged and in some instances, were ineffectively repaired with tape or tissue paper, or in others were not repaired at all. This damage was not documented or risk assessed and there were no control measures implemented to mitigate against the risk of the spread of fire due to ineffective fire containment systems.

There was a specific risk in one of the houses in regards to choking. There had been an incident of choking in the past 12 months, for which staff were required to physically intervene in order to respond to the incident and ensure the safety of the resident. The inspectors were not assured that there were adequate control measures implemented to mitigate against this risk. For example, the inspectors were told that all staff had completed basic online first aid training. However, only two out of eight staff were up-to-date in in-person first aid training at the time of the inspection. The provider informed the inspectors subsequent to the inspection that all staff had been enrolled on in-person first aid training and that this would be completed during February.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had implemented measures to respond to risks identified in relation to infection prevention and control (IPC) on a previous inspection of the centre. For example, standard operating procedures had been implemented in relation to environmental cleaning and the management of spills of blood and bodily fluids. There were good practices such daily, weekly, and monthly cleaning checklists for staff to complete. Staff spoken with were informed regarding standard and transmission based precautions. Inspectors also observed staff reminding residents about good hand hygiene.

However, inspectors also identified a number of areas that required improvements in order to ensure compliance with the National Standards for infection prevention and control in community services. These included:

- The hand-washing facilities in some areas were poor, for example, there was an absence of suitable waste receptacles, soap and hand towels at hand-

washing sinks.
- The storage of cleaning equipment was not appropriate, for example, inspectors observed dirty mop buckets stored in outdoor open wooden units exposed to elements and possible pests.
- In one home, there was an absence of appropriate chemicals and equipment for the safe cleaning and management of bodily fluid spills (however, the appropriate chemicals and equipment was sourced before the inspection concluded).
- Cleaning schedules did not include all required duties such as cleaning washing machines.
- The storage of residents' personal grooming products required better management to reduce the risk of infection cross contamination, for example, inspectors observed a shaving razor on the shower room floor.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had failed to implement fire safety systems, particularly in relation to their measures to contain potential smoke and fire. Overall, inspectors were not assured that fire-related risks had been assessed as there was no documented fire risk assessment. The following issues were observed in the designated centre:

- many fire doors did not have self-closing devices, and therefore were comprised in effectiveness.
- many fire doors were damaged. Some damaged parts were covered by tape or filled with tissue paper. This compromised the effectiveness and integrity of the fire doors
- in one instance, a fire door was missing a glass panel. This had not been identified as requiring repair
- fire doors in one house were held open by furniture
- fire response plans did not reference the addressable fire panel
- servicing records from December 2023 indicated that some emergency lights required replacement, however written assurances were not available to show that the lights had been replaced.
- fire safety checks were not being carried out as scheduled in some units
- there was no schedule for checking aids used to prompt residents if the fire alarm sounded to ensure that they were kept in good working order.
- a number of emergency exit doors required keys to open them and were not thumb-locked. In one instance, there was no spare key provided through a break glass box beside the emergency exit
- it was not established if glass panels above doors were fire-certified
- a keypad had been installed at the entrance to a house and the impact of this on fire evacuation had not been risk assessed

An immediate action was addressed on the day of inspection in order to mitigate

against some of the fire containment risks in one of the houses. The provider was required to move furniture which was holding open fire doors between the dining room and the sitting room. This was to assist in containing fire if fire were to break out in the kitchen and dining room area. The person in charge and staff team moved the furniture and closed the fire doors before the inspectors left.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The use of restrictive practices had significantly reduced in recent months due to the reconfiguration of the centre to better meet residents' assessed needs. The reduction in the use of restrictions had been managed in a considerate manner with consultation with the residents' concerned, and was having a positive impact on their lives.

However, some improvement was required to the identification and management of restrictive practices. Inspectors saw two additional restrictions which had not been been recognised as such. These were the placement of bells on exit doors in some of the houses and the use of an electronic keypad lock in one house. The use of the bells restrictions had minimal impact on residents, and staff were clear on the rationale for these, however, it could not be demonstrated to inspectors that they were implemented in line with evidence based best practice.

The use of the keypad lock required review as it was not determined what was the function or the rationale for this restrictive practice.

Judgment: Substantially 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Fairview OSV-0005301

Inspection ID: MON-0040742

Date of inspection: 01/02/2024

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: 1.1: The Provider acknowledges the large governance responsibilities of the designated centre and will commission an independent review from an external consultant to ensure governance arrangements are fit for purpose and make recommendations in relation to this by October 2024. 1.2: As an interim measure while this review is in process, the provider will establish a supernumerary position in the designated centre to support the Person in Charge (PIC) with oversight and governance. This role will be in post in May 2024. The objective of this post will be to improve local governance, quality responsiveness and to support the role of the PIC. This post will enhance the quality-of-service provision and our impact on delivering quality services and to more consistently track progress on action plans across audits within the designated centre. 1.3: This additional role will support the PIC to ensure that all staff employed within the designated centre receive a comprehensive refresher and awareness program to ensure that they are informed and effective in their roles. The delivery of this program will cover the responsibilities of staff in relation to practice (behaviour support), health and safety including fire safety, risk management, IPC, restrictive practices and safeguarding. Work on this has commenced on foot of the most recent inspection and the provider is committed to delivering this program to existing staff June 2024.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 23(1)(b) The Provider will ensure that all staff employed within the designated centre will receive a comprehensive refresher and awareness program to ensure that they are informed and effective in their roles in line with the organisational chart. This program will cover the responsibilities of staff in relation to practice (behaviour support), health and safety including fire safety, risk management, IPC, restrictive practices and safeguarding. Work on this has commenced on foot of the most recent inspection and the provider is committed to delivering this program to existing staff in June 2024. Additionally the newly designed organisational chart will be reflective of our current governance and reporting structures and will be completed by June 2024. The organisational chart will inform staff of the clearly defined roles, reporting structures and governance flow within the designated centre and across Gheel. The quality and safety team will develop a risk awareness training program based on the HSEland Risk and Incident Management module and will incorporate service specific scenarios and examples to inform staff of their roles and responsibilities in identifying and actioning risks and incidents in the designated centre on a day-to-day basis. This will also address how to report incidents on Q-pulse, appropriate language and required detail. The quality and safety team will deliver to all PIC and Location Managers (LM) in the service. The LMs will be responsible for delivering it to their staff teams. The quality and safety team will develop this program by April 24, to be delivered to staff in the designated centres in June 2024. The PIC has commenced designing a centre specific comprehensive induction and welcome pack for all staff onboarding within the designated centre. This will aid and facilitate practitioners to be knowledgeable about the responsibilities of their role. This program will cover the responsibilities of staff in relation to practice (behaviour support), health and safety including fire safety, risk management, IPC, restrictive practices and safeguarding. This will be rolled out by LM to new staff upon joining the organisation in April 2024. Refresher and awareness training will be rolled out to existing staff in June 2024. 23(1)(c) The provider has sourced a surveyor with expertise in fire safety as of 11/03/24 to commence a full audit and assessment of fire safety arrangements within the designated centre and to produce risk rated recommendations to the provider. This assessment will commence in March 2024 as an immediate priority. The provider is committed to delivering on all actions and/or issues by June 2024 highlighted within this assessment and will commence work systematically relative to risks upon receipt of the assessment. 23(2)(a) The quality and safety team will review and enhance the Quarterly Quality and Safety Walkaround template in March 2024. The PIC will implement the revised Quarterly	

Quality and Safety walkarounds commencing April 2024 and ensure identified actioned items are progressed to completion. Additionally, the PIC and LM will maintain greater oversight of completion of the health and safety registers as an additional layer for tracking of actions.
The Quality and Safety team will conduct a review of their biannual audits to enhance the audit to better capture and track that identified actions are being progressed to completion. This process will be implemented in April 2024.

The quality and safety team will review and update the suite of H&S registers (hygiene, H&S, food safety, fire safety, vehicle) to ensure that all H&S and IPC risks are captured. The quality and safety team will incorporate fire risk actions identified by the Fire Engineer into the health and safety register to ensure a systematic response to actioned items. This work will be completed in June 2024.

The PIC will ensure IPC, fire safety, risk management and restrictive practices are permanent fixtures on all agendas for team meetings from April 2024 to ensure ongoing discussion amongst teams to promote a continuous learning culture. The PIC will ensure any issues highlighted in discussion are followed up on in a timely manner and escalated as appropriate to ensure all issues are consistently tracked across appropriate departments and disciplines within Gheel.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Regulation 17: Premises
Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

17(1)(a)

The PIC and the LM will ensure that the maintenance of all premises (Homes) undertaken will be autism informed and give consideration to the individual sensory needs of residents, choice and preferences will be captured at the bi-weekly Voice and Choice meetings to ensure we are working in partnership and in alliance with the people we support. This consultation process has commenced will be a continuous agenda item at the bi-weekly Voice and Choice meeting with residents, this will be completed by June 2024.

The PIC will organise for all damaged furniture to be removed from the premises as an immediate action and that they are replaced in consultation with residents considering the choice and preferences of individuals. This will be completed by June 2024.

17(1)(a)

The PIC has actioned the maintenance department to remove any items i.e. kitchen appliances, fixture and fittings stored in the gardens and communal areas. This work

has commenced and will be completed by April 2024. The PIC is currently in consultation with the grounds horticulturist to further develop the grounds to be a homely, sensory friendly, and tranquil environment for the residents at Fairview.

17(1)(b)

The provider recognises that the upgrade the bathrooms and showers in the single storey apartments is a priority in terms of meeting quality, safety and infection prevention and control standards, and is committed to completing all outstanding work by September 2024. The PIC has commenced the process of precuring work for one of the resident's bathrooms as an immediate priority as it was identified the environment was having a negative impact on their experience of living in the apartment. This work will be completed by June 2024.

17(1)(b)

The provider is developing a maintenance workplan to address all of the upgrades required to premises to ensure the Designated Centre is homely and in a state of good repair and to ensure it is well maintained. This workplan will outline all of the works required and will be completed by June of 2024. In June 2024 the works will be prioritised for completion based on risk assessed criteria. The provider is committed to completing all works by December 2024 with due consideration for the sensory needs of all residents.

17(4)

The Quality and Quality team will review and update the suite of H&S registers (hygiene, H&S, food safety, fire safety, vehicles), including equipment and individual aids to ensure that all H&S and IPC risks are captured and tracked to completion. The quality and safety team will incorporate fire risk actions identified by the Fire Engineer. This will be completed by June 2024.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Quality and Safety team will develop an awareness training program to enhance staffs capacity and awareness of risk management this training will incorporate service specific scenarios and examples to inform staff of their role and responsibilities in identifying and actioning risks and incidents in the designated centre on a day-to-day basis. The quality and safety team will deliver this training to all PIC and LM in the service. The LM will be responsible for delivering it to their staff team. The Quality and Safety team will develop this program by end April 24, to be delivered to staff in the designated centres in June 2024.

As an additional layer to improve the management of risk, the Provider will ensure that all staff employed within the designated centre receive a comprehensive refresher and

awareness program to ensure that they are informed and effective in their roles in risk mitigation. The provider will deliver this program to all staff in the designated centre, all staff will have received this refresher by June 2024.

The PIC will ensure that all staff attend mandatory training. The PIC will ensure compliance with training requirements as part of the Quarterly Quality reviews, monitoring training attendance to ensure the tracking and oversight of staff training records.

The quality and safety team will review and enhance the Quarterly Quality and Safety walkaround template in March 2024. The PIC will implement the revised quarterly Quality and Safety walkarounds commencing in April 2024 and ensure identified action items are progressed to completion.

The Quality and Safety team will conduct a review of their biannual audits to enhance audit follow-up to ensure that identified actions are being progressed and completed. This will be completed in April 2024.

The PIC will ensure that all risks identified from audits are entered on the appropriate risk registers (Service and care, individual risk management and Health and Safety risk registers). The PIC will ensure that risk/incident management are escalated to the appropriate oversight departments and disciplines. Risk Management will be a permanent agenda item at team meetings from April 2024 to improve information flow and to promote staff awareness of their role and responsibilities in relation to quality and risk management. This process and the additional governance post in the designated centre will support the PIC to better monitor risk and support staff in their understanding of their role in the identification and escalation of risk management.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The provider is committed to promoting compliance while implementing the national clinical IPC guidance within the designated centre. The provider has appointed two IPC leads who have completed IPC Link Practitioner training program in February 2024. whose role it is to review national standards and guidance on standards relating to prevention of infection and control and to inform policy and procedures.

The two IPC leads are members of the National Disability IPC group and attend monthly meetings with the purpose of gathering IPC knowledge and expertise. The IPC leads will ensure that information is communicated to PICs on a monthly basis or immediately as required.

The National Disability IPC group is developing a one-day IPC Foundation Programme for all staff in social care services. Estimated completion date end of June 2024. The IPC Link Leads will be trained on this and will commence roll out of the training to all staff in Gheel as soon as they have been trained. In the interim all staff in the designated centre will have completed IPC AMRIC by June 2024 . The PIC will monitor staff attendance of

training and maintain staff training records.

The IPC Link Leads in Gheel have commenced bi-weekly meetings to discuss IPC related issues and topics. They will commence unannounced IPC walkarounds in locations from end March 2024 to identify IPC risks and ensure the appropriate follow up actions are implemented.

The quality and safety team will review and enhance the Quarterly Quality and Safety walkaround template to include IPC in March 2024. The PIC will implement the revised Quarterly Quality and Safety walkarounds commencing in April 2024 and ensure identified action items are progressed to completion. Additionally, the PIC and location managers will maintain greater oversight and ensure a systematic response to actioned items.

The Quality and Safety team will conduct a review of their biannual audits to capture and enhance audit follow-up and ensure that identified actions are being progressed and completed. Biannual audits will include IPC from April 2024.

The Provider will ensure that all staff employed within the designated centre receive a comprehensive refresher and awareness program developed by the quality and safety team which will be developed to promote awareness. This training program will incorporate service specific scenarios and examples of IPC risks to inform staff of their role and responsibilities in identifying and actioning IPC risks in the designated centre on a day-to-day basis. The quality and safety team will deliver the refresher and awareness training to the PIC and LM in the designated centre. The LMs will be responsible for delivering the refresher and awareness training to their staff teams. This refresher training will be developed by April 24, to be delivered to all staff in the designated centre by June 2024.

The PIC/LM will monitor IPC knowledge and practices through audit/walkarounds and oversight of the H&S registers. The PIC/LM will communicate learning at staff meetings in which IPC will now be a permanent agenda items at team meetings from April 2024.

The provider is developing a maintenance workplan to systematically address the depreciation of premises, upkeep and renovation in the context of IPC and to ensure the Designated Centre is homely and in a state of good repair. This workplan will outline all the works required and will be completed by June of 2024. All recommended renovations will be designed to promote IPC standards (hand hygiene storage of mop and mop buckets) with IPC consideration to the design and materials used. In addition, with all renovations consideration will be given to preserve the dignity, privacy, will and preferences of residents.

The provider is also committed to maintaining the premises to a level of quality and safety standards in order to achieve the aims and objectives of the service and the identified needs of each person residing in the designated centre. To meet this objective, the provider will commission an external surveyor of all additional remedial maintenance works to be carried out in the designated centre in relation to Fire Safety and Prevention.

The Quality and Safety team will incorporate any actions identified into H&S registers,

walkarounds and audits. The provider will ensure that the resources are provided to complete the remedial works in the order of risk rated priority. This work will be fully assessed by the end of June 2024.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The provider has sourced a Fire Engineer with expertise in fire safety as of 11/03/24 to commence a full audit and assessment of fire safety arrangements within the designated centre and to produce risk rated recommendations to the provider. This assessment will commence in March 2024 as an immediate priority. The provider is committed to delivering on all actions and/or issues highlighted within this assessment and will commence work immediately upon receipt of the assessment.

The Quality and Safety team will review and update the Fire Registers and the Health and Safety Walkaround once they receive the surveyor assessment. The Quality and Safety team will incorporate all fire risk actions identified by the Fire Engineer into the registers to track and monitor progress in June 2024.

The Provider will ensure that all staff employed within the designated centre receive a comprehensive refresher and awareness program to ensure that they are informed and effective in their roles in line with the organisational chart. This program will cover the responsibilities of staff in relation to practice (behaviour support), health and safety including fire safety and risk management. Work on this has commenced on foot of the most recent inspection and the provider is committed to delivering this program to all staff in the designated centre by June 2024.

The quality and safety team will develop a training program based on the HSEland Risk and Incident Management module and will incorporate service specific scenarios and examples to inform staff of their role and responsibilities in identifying and actioning risks and incidents in the designated centre on a day-to-day basis. This program will address the process for reporting incidents on Q-pulse, appropriate language and required detail. The Quality and Safety team will deliver this training to all PIC and LM in the designated centre. The LM will be responsible for delivering it to their team. This will be developed by April 24, to be delivered to all staff in the designated centre in June 2024.

The PIC will deliver the revised quarterly Quality and Safety walkarounds commencing in April 2024 which will ensure identified action items are progressed to completion.

This process will aid the PIC and LMs to maintain greater oversight of completion of the Fire registers.

The PIC will ensure IPC, fire safety, risk management and restrictive practices are permanent fixtures on all agendas for team meetings from April 2024 to ensure ongoing discussion amongst teams to promote a continuous learning culture. The PIC will ensure any issues highlighted in discussion are followed up on in a timely manner and escalated to appropriate disciplines and departments to ensure all issues are consistently tracked across the designated centre.

The PIC will maintain records from MasterFire of all our inventory of fire safety equipment, emergency lighting, alarm panels, fire extinguishers, fire blankets to meet the fire standards and to have readily available for inspection. This action was completed as of the March 2024.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Restrictive Practice Committee has commenced Restrictive Practice Walkarounds in all locations in the designated centre. The aim of these walkarounds is to monitor Restrictive Practices that are in place and currently returned to HIQA in the Quarterly returns and to identify any practices which are restrictive and are not currently recognised as restrictive. Walkarounds in Fairview designated centre are now completed and reports will be issued to the PIC by end March 2024. The restrictive practice committee will monitor completion of actions identified in the walkarounds.

A new form 'Basic Human Rights and Restrictive Practice' has been developed and sent out to all locations. This form will facilitate keyworkers to assess each person's basic human rights and will support them to identify and address any restrictive practices. This form will be completed by keyworkers by April 2024, actions to be addressed by June 2024. Any issues that cannot be addressed as a matter of priority will be referred to the Restrictive Practice Committee and returned in the quarterly returns to HIQA.

The Quality and Safety team will review and enhance the Quarterly Quality and Safety walkaround template to include Restrictive Practice by the end of March 2024. The PIC will implement the revised quarterly quality and safety walkarounds commencing in April 2024 and ensure identified action items are progressed to completion. Additionally, the PIC and LMs will maintain greater oversight of the health and safety registers.

The Quality and Safety team will conduct a review of their biannual audits to enhance audit follow-up to ensure that identified actions are being progressed and completed. Biannual audits will include the identification and monitoring of Restrictive Practices by the end April 2024.

The quality and safety team will develop a training program based on the HSEland Risk and Incident Management module and will incorporate service specific scenarios and examples (including Restrictive Practices) to inform staff of their roles and responsibilities in identifying and actioning risk management and incidents in the designated centre on a day-to-day basis. This will also address how to report incidents on Q-pulse, appropriate language and required detail. The Quality and Safety team will deliver this program to the PIC and LM in the designated centre. The LMs will be responsible for delivering it to their team. This program will be developed by end April 2024, and will be delivered to all staff in the designated centre in June 2024

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Substantially Compliant	Yellow	31/10/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	28/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the	Not Compliant	Orange	31/12/2024

	designated centre are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	28/06/2024
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	28/06/2024
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	28/06/2024

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively 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.	Not Compliant	Orange	28/06/2024
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	28/06/2024

Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	28/06/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	28/06/2024
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	28/06/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape,	Not Compliant	Orange	28/06/2024

	building fabric and building services.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	28/06/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	28/06/2024