Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Adults)

Name of designated centre:	Fairview
Name of provider:	Gheel Autism Services Company Limited by Guarantee
Address of centre:	Dublin 3
Type of inspection:	Announced
Date of inspection:	20 March 2019
Centre ID:	OSV-0005301
Fieldwork ID:	MON-0022599

About the designated centre

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

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

The following information outlines some additional data on this centre.

Current registration end date:	02/08/2019
Number of residents on the date of inspection:	21

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
20 March 2019	09:30hrs to 17:30hrs	Sarah Mockler	Lead
20 March 2019	09:30hrs to 17:30hrs	Michael Keating	Support

Views of people who use the service

The inspectors had the opportunity to meet with 13 of the residents, across different parts of the day. Due to the assessed needs of some of the residents the inspectors spent some time briefly observing them in their homes. Some residents were very eager to speak with the inspectors and tell them about what was important to them, such as activities in their local community, holidays and the different items they liked to collect. A resident wanted to know what the inspectors plan was for the day, and inspectors spent time discussing this with the resident. Residents appeared happy and content in their homes. All residents observed were very comfortable in staff presence and it was evident that staff were very responsive to their individual needs, preferences and communication styles.

Residents' views were also taken from the Health Information and Quality Authorities questionnaires for residents, and various other records that endeavoured to voice the residents' opinion, such as the annual review. Four of the questionnaires were directly filled out by residents and they all indicated they were very happy with where they lived. In the annual review residents and also there representatives had an opportunity to contribute through specific forums and key working session and questionnaires. Overall the findings of the annual review report found that the quality of care provided was excellent.

Capacity and capability

The inspectors found that the registered provider and the person in charge were effective in assuring a good quality service was provided to the residents. Due to the effective governance in the centre there were positive outcomes for residents, person centred care ensured that an inclusive environment was promoted where each residents' specific needs were considered. Some improvements were required in relation to the complaints documentation process however this was in no way impacting on how the complaints were investigated or resolved.

On the day of inspection the Director of Autism Practice discussed with the inspectors the recent transition process occurring within the governance structure of the organisation. The pending changes overall had the aim to further strengthen the service provided to residents and the strategic direction of the service provision. Although these changes were in transition, it was evident that this had no impact at any level on the service provision for the residents.The management structure was clearly defined with clear lines of accountability and authority. The person in charge was a full time role and they directly reported into the Director of Services. The location managers were responsible for the houses and apartments. They were directly supervised and managed by the person in charge. Staff were supported to effectively exercise their personal, professional and collective accountability for the provision of effective and safe care. Staff were well supported in all their roles.

There were appropriate systems and processes in place that underpinned the safe delivery and oversight of the service. There was an annual review of the quality and safety of care and support in the designated centre. The person in charge had systems in place to monitor the quality of care and support for residents including a suite of audits which were completed regularly. The suite of audits included and were not limited to; care plans, medication, personal evacuation plans and finances. These reviews were identifying areas for improvement, and actions from these reviews were impacting positively on residents care and support and their home.

There were enough staff with the right skills, qualifications and experience to meet the assessed needs of residents. Safe and effective recruitment practices were in place and ensured an appropriate skill mix was available to the residents. There was a person in charge who had oversight for the four location managers. The location managers, autism practioners, support workers, and nurses directly supported the residents on a day to day basis. Respect, equality, dignity and autonomy of the residents, was very much upheld by all staff which resulted in a very supportive environment for the residents. Residents reported that staff were respectful and kind. This was observed throughout the day of inspection. A lovely interaction style with residents was observed, which was considerate of the residents assessed needs and wishes. Questionnaires for residents filled out by both family members and the residents indicated that staff were very respectful of the residents space, will and preference and were very helpful. All information in the questionnaires indicated residents and family members were very happy with the arrangements in place for the residents. There was continuity of staffing promoted within the centre, on the day of inspection there was 0.6 whole time equivalent staff vacancy however the recruitment for this position was in the final stages.

The staff training needs and development was organised and managed in a way to ensure that they had the required skills, experience and competencies to respond to the individual needs of the residents. There was an online system for monitoring staff training requirements, which generated a daily live overview of training. This ensured staff received all required and refresher training in a timely manner. There was a key worker system in operation.

There was a compliments and complaints record in each location. It was evident that the provider had established systems to address and resolve any issues that arose. However on discussion with the relevant person it was evident that there was a separation of formal versus informal complaints. Although informal complaints were addressed in an appropriate manner they were not recorded or documented in line with the organisations policy or the regulations. This gap in the documentation process did not impact on how the any of the issues identified were resolved or the quality of care delivered to residents.

Schedule 5 policies and procedures were reviewed and all policies had been recently updated. The provider was in the process of updating the policies to ensure that they best reflected and guided staff practice in relation to the specific assessed needs of the residents.

Regulation 15: Staffing

There were enough staff with the right skills, qualifications and experience to meet the assessed needs of residents. Information and documents specified in Schedule 2 were available.

Judgment: Compliant

Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date, evidence based practices. All staff were supervised appropriate to their roles.

Judgment: Compliant

Regulation 23: Governance and management

The management structure was clearly defined and identified the lines of authority and accountability, specified roles and detailed responsibilities for all areas of service provision. Management systems were in place to ensure that the service provided was appropriated to residents' needs, consistent and effectively monitored.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The centre's admission process considers the wishes, needs and safety of the individual. A written contract for the provision of services was agreed on admission.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints process was user friendly, accessible to all residents and displayed prominently. While there was appropriate polices, procedures and practices in place,

there were some gaps in the associated documents that did not result in a medium or high risk to residents using the service.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All Schedule 5 policies and procedures were reviewed as often as the Chief Inspector may require and were at least reviewed and updated at intervals not exceeding three years and, where necessary, to reflect best practice.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that the provider and person in charge were striving to ensure that the quality of the service provided for residents was person centred and suitable for the assessed needs of the residents. The centre was managed in a way that maximised residents' capacity to exercise independence and choice in their daily lives. On the day of inspection the residents were getting ready to engage in meaningful activities of their choice. Residents spoke about the different types of activities they liked to do in their community and inspector observed some residents getting ready to go out to their activity of choice. Staff were very knowledgeable about the residents' preferences, needs and communication style and every effort was made to ensure that the resident was involved in all aspects of their day. However improvements were required in relation to the compatibility of residents living within one house and also in relation to fire containment measures.

Each of the houses and apartments were homely and decorated to the individuals needs and wishes. Each bedroom was decorated to the individuals personal taste with items and pictures that were meaningful to the individual. Each residence had it own specific layout and adaptations, dependent on the needs of the residents living there. In one of the homes some residents needed help with mobility and the provider had the necessary adaptations made to the building. There was adequate space and suitable storage facilities available for the personal use of residents. In some of the homes it was noted that the bathrooms required updating, however the provider had identified this and was in the process of getting quotes for this work.

Residents were supported to bring their own belongings into their rooms. There was enough space for each resident to store and maintain clothes and other important possessions such as their individual collectable items.There was a list of personal possessions kept on each individuals' personal plan and this was reviewed

and maintained as necessary.

Residents were encouraged to eat a varied diet as appropriate. There were accessible menu planners on view in each kitchen and menu planning was discussed with residents either on a weekly or daily basis. There was adequate facilities to store food. The advice of speech and language therapists and dieticians in relation any modified diets was implemented and monitored.

The provider and person in charge were actively trying to protect residents from all forms of abuse. The person in charge had initiated and put in place an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where a resident was harmed or suffered abuse. Safeguarding plans, were required, had been put in place and were monitored to ensure there effectiveness. However in one of the houses there was compatibility issues between some of the residents. A number of alleged safeguarding incidents had occurred in 2018 and were reported to the safeguarding team and regulator as required. Appropriate actions had been taken to try to ensure the safety of the residents. The provider had identified the issue with compatibility and outlined their plan to address this. However, this plan was dependent on a number of factors so there was no clear time line in place to resolve this issue for the residents concerned.

Documentation was reviewed in relation to a transition that had occurred in the centre. An accessible version of the transition plan was made available to the inspectors. This plan was comprehensive and had evidence to show how and when the resident was consulted in the process. In the accessible transition plan, the resident had circled the items they wanted to have in their new bedroom.The resident had also chosen dates to visit and stay in their new home before they officially moved into the centre.

All staff had received suitable training in fire prevention and emergency procedures. The registered provider had ensured that all fire equipment was maintained and serviced at regular intervals. There was adequate means of escape, including emergency lighting. All escape routes were clear from obstruction.The mobility and cognitive understanding of residents had been considered and appropriate emergency plans had been developed. This included emergency packs for individuals which contained visuals and objects required for the safe and successful evacuation of the residents. Fire drills were completed with staff and residents at suitable intervals. However on the day of inspection the provider failed to have adequate arrangements for suitable fire containment in some of the houses. Some fire doors were found to be wedged opened in two of the houses. A fire door fitted with an automatic closer failed to work. This fire door was located in a high risk area. The inspectors sought immediate assurances in relation to this on the day of inspection.

Policies and procedures in medicine management were reflected in practice. Medicine was stored in a locked safe and there was a procedure in place for key holding. All staff had received training in the safe administration of medication and have also passed a competency based assessment. A staff member was able to discuss the process in relation to a medication error and this was in line

with relevant protocols and policies. All residents had completed self administration of medication assessments, and where appropriate residents were enabled to administer their own medication. Regular stock checks were completed in relation to medication. Monthly medication audits were also completed and any learning identified from these audits was implemented into practice.

There was a strong and visable person-centre culture within the organisation with residents receiving the care they need. Assessments and plans described the abilities and needs of each resident in an individual way. Visual aids such as social stories were used across the personal planning process to ensure that the plan was suitably accessible to the residents. In addition to this visual supports were evident throughout the residents homes to ensure meaningful participation in many different everyday activities. A resident spoke to the inspector about the support plans in place for them.

Residents who are eligible, by means of gender, age or condition, are made aware and supported to access, if they so wish, the National Screening Services. The provider had made considerable effort in ensuring that all residents could access this program and had identified significant issues with gaining consent from some of the residents due to their assessed needs. The provider had addressed this by developing a specific risk profile for each resident with the support of their GP. The risk profile considered elements such as family history, behavioural changes and abnormal blood results. The outcome of the risk profile enabled the relevant professionals to make a decision on the appropriate care required. Every effort was being made by the provider to provide information on the screening process in an accessible format to the residents.

The residents' had appropriate supports in place in relation to positive behaviour support plans and access to relevant allied professionals. Where required, therapeutic interventions were implemented with the informed consent of the resident, and accessible versions of the behaviour support plan were made available. There was a positive behaviour support plan and a document called 'How to support me' in place to guide staff practice. The 'How to support me' had an operationally defined behaviour and relevant proactive and reactive strategies. However the documentation process in relation to positive behaviour support plans required development as it failed to document the proactive strategies described in the 'How to support me' plans. This was not having any impact on the care and support provided to residents.

In one of the homes a significant amount of restrictions were in place due to the assessed needs of one of the residents. These restrictive practices were reviewed regularly, subject to relevant audits and reported as per regulations. The provider had a plan in place to further reduce these restrictions as they had recognised the impact the restrictions were having on all residents in the home. This plan required the resident to transition to an adapted house. The process in relation to the building and development of this property was in the early stages. The location manager described how the resident and their representative had been consulted in the planning stages of the development of this home.

Regulation 12: Personal possessions

Residents were supported to bring their own belongings into their rooms. There was enough space for each resident to store and maintain clothes and other possessions. There was a list of personal possessions kept on each individuals personal plan and this was reviewed and maintained as necessary.

Judgment: Compliant

Regulation 17: Premises

In general the premises was well maintained with suitable individual and communal space. Rooms were of a suitable size and layout suitable for the needs of residents.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were encourage to eat a varied diet with the input of appropriate professionals, for example speech and language therapists, dieticians. Food was modified if required but regularly reviewed with the aim of enhancing residents diet and options.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

There was a comprehensive transition plan completed when required. It was evident that the resident and their representative were consulted in the process.

Judgment: Compliant

Regulation 28: Fire precautions

The procedures to be followed in the event of of a fire were displayed appropriately. There was adequate means of escape including emergency lighting. However in two

of the houses some fire doors were wedged open. In one of the house, a fire door in a high risk area had an automatic closer which was not working.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Practice relating to the ordering, receipt, prescribing, storing, including medicinal refrigeration, disposal and administration of medicines was appropriate.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a comprehensive assessment completed for each resident which identified the individuals' health, personal and social care needs. the outcome of the assessment was used to inform an associated plan of care for the residents and this was recorded as the resident's personal plan.

Judgment: Compliant

Regulation 6: Health care

Appropriate healthcare was made available for each resident, having regard to that resident's personal plan. There was evidence to demonstrate that residents were supported to make decisions regarding the National Screening Services and were facilitated it attend if they wished.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were appropriate supports in place for residents with behaviours that challenge. Staff have up-to-date knowledge and skills appropriate to their roles.

Judgment: Compliant

Regulation 8: Protection

The provider and person in charge were actively protecting residents from abuse however due to the compatibility of some residents in one of the houses there had been numerous alleged incidents between residents.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 28: Fire precautions	Not 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	Substantially compliant

Compliance Plan for Fairview OSV-0005301

Inspection ID: MON-0022599

Date of inspection: 20/03/2019

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 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: A full review of the Complaints policy has been undertaken to address both the formal and informal receipts. The necessary changes have been introduced, to ensure full compliance.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The doors will no longer be wedged open and the automatic closer has been repaired and is now in perfect working order.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: We have commenced the process of moving one of the residents concerned into their own semi-independent apartment. The length of time that this will take is determined by another resident who currently resides in this semi-independent apartment. This resident has expressed a desire to move out of this apartment and into the community and the process of accessing a Housing Assistance Payment (HAP) and searching for a suitable property has already begun. We hope to have the process completed by the end of 2019.	

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 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	29/04/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	29/04/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2019