Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	The Gables
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Meath
Type of inspection:	Unannounced
Date of inspection:	11 December 2024
Centre ID:	OSV-0007771
Fieldwork ID:	MON-0045756

About the designated centre

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

The Gables is a designated centre situated in a rural setting, just outside a small town in Co. Meath. Residential care and support in provided for up to four children with disabilities both male and female aged between 11 to 18 years of age, with a wide range of support needs including Intellectual Disabilities and Autism Spectrum Disorder (ASD). The main house is a single storey building which contains a kitchen, dining area/lounge, play room and office, together with three individual living areas, one with its own bedroom and bathroom and the other two with bedrooms, bathrooms and living areas. There is also a self-contained apartment adjacent to the main house. Children are supported 24 hours a day, seven days a week by a staff team consisting of a person in charge, team leaders, social care workers, assistant support workers and relief staff. There is transport provided for children to ensure they can access their local community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 11 December 2024	10:30hrs to 18:15hrs	Julie Pryce	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection conducted in order to monitor on-going compliance with the regulations.

The person in charge (PIC) was on a long term absence at the time of the inspection, so the inspection was facilitated by one of the team leaders who was covering for the absence of the PIC. This team leader was knowledgeable about the care and support needs of each resident.

There were four children resident in the designated centre on the day of the inspection, and the inspector met all of them. Two of them were out at activities or school in the morning, and returned to the designated centre later in the day.

Following the introductory meeting, the inspector conducted a 'walk around' of the designated centre, and found that the premises were laid out in accordance with the needs of residents. There were various play areas available to the children, including outside areas which included a trampoline, swings and goal posts to support the play of children. Inside there was a soft play area, and each resident's room had items for both play and for learning.

Three of the residents had self-contained apartments, and the other had their own bedroom and bathroom and utilised the main living area and kitchen. On the day of the inspection all areas were decorated for Christmas, there was a Christmas tree in each apartment, and each resident had chosen how to decorate their home.

During the inspection the team leader knocked on each resident's door to ask if they would accept a visit from the inspector, so that it was clear that the rights of residents to choose who entered their apartment was upheld.

One of the residents was enjoying play in their apartment, which involved a sensory activity. They accepted a visit to their apartment by the inspector, and showed the inspector their 'slime' which they were clearly engrossed in. They allowed the inspector to briefly join in with their activity, and to see the other items. There were items to assist communication in the form of a picture exchange communication system (PECS).

The other resident who was at home in the morning said that they were happy for the visit, but didn't want to chat. When the inspector entered the apartment the resident said a cheery 'hello' and then continued with their activity. They said it was ok for the inspector to go into their bedroom and look at their bathroom, so the inspector did not make any further attempt to engage them. Later on in the day the inspector observed them preparing for an activity, and saw that they were comfortable with the staff members who were supporting them. They waved in through the window to another resident who was to join them for the next activity. This resident gave a cheery wave back, and it was clear that the two residents were

good friends.

This third resident had arrived home from another activity, and had a chat with the inspector when they came in. The conversation was mainly about the role of the inspector, who was a stranger to them, and this was briefly explained to them. The inspector asked who they would go to if they had a problem, and they named the team leader, so that it was clear that the recent changes in local management had been made available to them.

They told the inspector that they would be moving next year because they would be turning eighteen years of age, and it was evident that they had been well prepared for this transition. They said they would keep in touch with their friend in this centre.

The other resident also came home from activities later in the day, and the inspector observed the team leader and staff communicating with them with their PECS. The resident was able to choose their snacks and their activities by this method.

Overall residents were supported to have a comfortable and meaningful life, with an emphasis on communication and supporting choice and preferences, and there was a good standard of care and support in this designated centre.

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

Capacity and capability

There was a clearly defined management structure in place, and lines of accountability were clear. There were various oversight strategies which were found to be effective in many areas of care and support, although some improvements were required in the availability of documentation.

There was a competent staff team who were in receipt of relevant training, and demonstrated good knowledge of the support needs of residents. Staff were supervised by the team leader in the absence ot the PIC. However, the organisation required each staff member to have two formal supervisions per year, and nine of the staff members had only received one such conversation this year.

All the required notifications had been submitted to HIQA within the expected timeframes.

Regulation 15: Staffing

There were sufficient numbers of staff to meet the needs of residents both day and night. A planned and actual staffing roster was maintained as required by the regulations. There was a consistent staff team who were known to the residents, including any relief staff.

The inspector reviewed three staff files, and found that they each contained all the information required by the regulations.

The inspector spoke to four staff members during the course of the inspection, and found them to be knowledgeable about the support needs of residents. Staff were observed throughout the course of the inspection to be delivering care in accordance with the care plans of each resident, and in a caring and respectful way.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector was unable to determine during the inspection whether training was up to date, however a training matrix was submitted the following day, which indicated that mandatory training was up-to-date.

Supervision conversations were required by the organisation to be held at least twice each year, but for nine members of staff only one of these conversations had taken place.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in place, and all staff were aware of this structure and their reporting relationships. The person in charge was on long term leave at the time of the inspection, and the inspection was facilitated by the team lead and the director of operations.

Throughout the inspection there were constant delays in providing documentation to the inspector. Documents were not readily retrievable, to the extent that the inspector was not assured that there was thorough and continuous oversight, or that local management had ready access to the documents that would inform continuous quality improvement, or have ready access to any required actions from any of the monitoring systems.

Some documents could not be located during the course of the inspection, and were required by the inspector to be submitted the following day. This included the

current matrix of staff training, and the annual review of care and support which is required by the regulations to be made available to the chief inspector.

The previous inspection had identified that documentation relating to the care order for one of the children was not available, and this issue was found again on this inspection. The care order on file for one of the residents related to their sibling, and not to the resident of the designated centre.

However, there were various monitoring and oversight systems in place. An Annual review of the care and support of residents had been prepared as required by the regulations, and six-monthly unannounced visits had been conducted on behalf of the provider. Any required actions identified during these processes are monitored until complete by means of an action plan which was developed by the person in charge.

Regular reports to senior management were made, including a daily report to the director of operations and a monthly Quality and Governance Assurance Report which was submitted to senior management.

Regular team meetings were held and minutes were maintained from each meeting. Items for discussion included an update on each residents, and safety interventions, and any accidents or incidents. The records of these meetings indicated that they were useful and meaningful discussions.

Overall while there were some effective oversight strategies, the difficulty in retrieving documents did not assure the inspector that the oversight of the centre was thorough and continuous.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All the required notifications had been submitted to HIQA, including notifications of any incidents of concern.

Judgment: Compliant

Quality and safety

There were systems in place to ensure that residents were supported to have a comfortable life, and to have their needs met. There was an effective personal planning system in place, and residents were supported to engage in multiple

different activities, and to have a meaningful day.

The residents were observed to be offered care and support in accordance with their assessed needs, and staff communicated effectively with them. Where residents required behaviour support there were detailed behaviour support plans in place which were developed and overseen by a behaviour support specialist.

There were risk management strategies in place, and all identified risks had effective management plans in place. Any newly identified risks were responded to in a timely manner. There were appropriate systems and processes in place to ensure fire safety.

The rights of the residents were well supported, and communication with residents was given high priority. Staff were knowledgeable about the support needs of residents and supported them in a caring and respectful manner.

Regulation 11: Visits

There was a clear policy on visits to the designated centre which had been regularly reviewed. There were risk assessments in place in relation to visitors to the centre, and all staff were aware of the guidance in these documents, and visits were facilitated in accordance with them.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a current risk management policy which included all the requirements of the regulations. Risk registers were maintained which included both local and environmental risks, and individual risks to the residents. There was a risk assessment and risk management plan for each of the identified risks.

Individual risk management plans included the management of behaviours of concern and self-injurious behaviours, the use of restrictive practices, and individual fire safety. They were based on detailed assessments, and clearly identified any required control measures.

There had recently been and unexpected adverse event while residents were using the hot tub and the risk had been mitigated immediately, not only for the use of the hot tub, but for all water play that residents were involved in. It was evident that risks were well managed in the centre, and changing circumstances were responded to effectively.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had put in place various structures and processes to ensure fire safety. There were self-closing fire doors throughout the centre and all equipment had been maintained. Regular fire drills had been undertaken, and there was a personal evacuation plan in place for each resident, giving guidance to staff as to how to support each resident to evacuate. Any aids which might assist with evacuation were in place, for example there were ear protectors available where required.

Fire drills were documented, and any learning from fire drills was documented, together with any learning. Fire safety was discussed with residents at key-working sessions, and social stories had been developed to aid understanding. The records of fire drills indicated that all residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

There were good practices in place in relation to the management of medications. The staff member on duty described to the inspector their practice in administering medication and it was clear that it was appropriate and in accordance with best practice.

The administration of any 'as required' (PRN) medication was in accordance with best practice. Staff described the steps they would take prior to considering the administration of medication, which was in line with the guidance in the personal plans of residents. If consideration was being given to administering medication, the staff consulted with management about the decision. Recording of the administration included the reason for administration, and the effect of the medication.

The residents had current prescriptions, and staff were knowledgeable about each medication. Most medications were supplied by the local pharmacist in 'blister packs', and receipt of medication orders was carefully checked. Where medications were supplied loose in containers, there were regular checks on stocks, and a reducing balance record was maintained. The stock of medications checked by the inspector was correct.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were personal plans in place for each resident which were audited at least annually and were based on a detailed assessment of need. Care plans in place included plans in relation to healthcare, including mental health, and the management of behaviours of concern. The plans gave detailed guidance to staff as to the support required by each resident.

Within the personal plans goals had been set with each resident in relation to maximising their potential. Goals were set in accordance with the preferences and abilities of residents, and steps towards achieving goals were clearly identified and recorded regularly, together with any resources required to support residents to achieve their goals. Goals related to learning new skills, such as personal care or learning about money management, and leisure activities such as art and crafts.

The person-centred plans were available in accessible version for residents, including short phrasing and pictures, and it was clear that the residents each made their own decisions as to their chosen goals.

Judgment: Compliant

Regulation 6: Health care

Residents had access to various members of the multi-disciplinary team (MDT) as required, including a dietician, a speech and language therapist, behaviour support specialist and mental health professionals.

There was a detailed healthcare plan in place for any identified healthcare issues which included detailed guidance for staff. Implementation of the plan was recorded daily so that it was clear that the supports were carried out as outlined, and staff were knowledgeable about the strategies in place.

There was a 'hospital passport' in place for each resident which outlined the important information should a resident have to be admitted to hospital.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required positive behaviour support, there were detailed plans in place, based on a detailed assessment of needs. Proactive strategies were identified, and staff could discuss the ways in which they were supporting residents to reduce

the occurrence of incidents of behaviours of concern. The plans outlined any identified precursors and triggers to incidents of behaviours of concern.

There were various strategies in place, including a 'zones of regulation' chart for one of the residents which supported them to self-regulate, and to identify their emotions so that staff could offer the appropriate support.

Staff had all received training in the management of behaviours of concern, and all staff engaged by the inspector were knowledgeable about their role in supporting residents, and could identify the strategies in place for each resident.

Where restrictive practices were in place to ensure the safety of residents, they were monitored to ensure that they were the least restrictive measures available to mitigate the identified risks. There was a restrictive practices register in place which included each intervention and the rationale for its use. All restrictions were overseen at a quarterly review meeting. Each restriction was discussed at these meetings, with an emphasis on reducing or removing restrictions where possible.

The reduction in restrictions included the gradual re-introduction of metal cutlery for one of the residents, and a skills teaching programme for another in relation to supporting them to have increased autonomy around finances. The inspector was assured that restrictions were only in place if they were necessary to safeguard residents.

Judgment: Compliant

Regulation 8: Protection

There was a clear safeguarding policy, and all staff were aware of the content of this policy, and knew their responsibilities in relation to safeguarding residents. Staff were in receipt of up-to-date training in safeguarding, and could discuss the learning from this training. Residents and their families knew who to approach if they had any concerns.

Staff were familiar with any safeguarding plans in the designated centre, and there was clear evidence that the plans were implemented.

However, the care order for one of the residents was not available in the designated centre, as outlined under regulation 23 of this report.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Staff had all received training in human rights, and could speak about the importance of supporting the rights of residents. They spoke about the ways in which they ensured that the voices of the residents were heard, and the importance of safeguarding of residents.

Residents were supported to communicate in various ways in accordance with their abilities, and staff were observed throughout the inspection to be supporting residents in a knowledgeable and caring manner.

Residents were involved in various activities, both leisure activities and learning opportunities, and were being supported to gain independence and to learn new skills.

Overall it was clear that staff were making all efforts to ensure that the voices of residents were heard and responded to.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Gables OSV-0007771

Inspection ID: MON-0045756

Date of inspection: 11/12/2024

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in Charge (PIC) will complete a full review of each Team Members supervision records and ensure that all Team Members have received supervisions in line Nua's Supervision policy. (PL – OPS – 017 Policy and Procedure on Supervision). 2. The Training matrix on file in the Centre will be updated by the PIC as and when training has been completed. 3. Where Central records are required linked to the Training matrix, this will be requested in a timely manner from the training department. A Copy of the most up to date training matrix will be maintained within the Centre. 4. The above points will be discussed with the staff team at the next Centre team meeting. Due Date: 28 February 2025	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Director of Operations (DOO) will review the Inspectors' feedback in relation to ensuring all documentation is readily available within the Centre with the Person in	

Charge (PIC). Learnings from this review will be communicated to all relevant stakeholders.

2. The Person in Charge (PIC) has requested ID311's care order from their Guardian Ad Litem (GAL). Once this is obtained this will be retained with their personal files.

3. The Quality Assurance Department will report on any issues identified during the unannounced six-monthly audits relating to access to documentation through the Regulation 23 report.

4. The PIC will ensure that any feedback received in the Regulation 23 report has a corresponding action which is closed out in a timely manner.

5. The PIC will ensure that all documentation relating to the Centre is maintained on the Centre's software system, allowing for shared access in the event of an inspection taking place.

6. The above points will be discussed with the staff team at the next Centre team meeting.

Due Date: 28 February 2025

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge (PIC) has requested ID311's care order from their Guardian Ad Litem (GAL). Once this is obtained this will be retained with their personal files.

2. The PIC will ensure that an in-date court order is on file for all Individuals, and this will be requested of their representatives following any scheduled court review.

3. On receipt of care orders, the PIC will ensure they contain accurate information relating to the Individual. Where an error is identified, this will be escalated immediately for remedial action.

Due Date: 14 February 2025

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	28/02/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	28/02/2025
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national	Substantially Compliant	Yellow	14/02/2025

	guidance for the protection and welfare of children and any relevant statutory requirements are complied with.			