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:	Stewarts Care Adult Services Designated Centre 17
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	28 November 2019
Centre ID:	OSV-0005851
Fieldwork ID:	MON-0027121

About the designated centre

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

Designated centre 17 is operated by Stewart's Care Limited. It is intended to provide long stay residential support to no more than eight men or women over 18 years of age with complex support needs. This centre comprises two wheelchair accessible homes located on a campus in Dublin 20. Each resident has their own bedroom, and each home has an open-plan kitchen, dining, sitting room, along with a wet room and access to a patio or garden. An activities programme is available seven days a week from within the centre. There is limited transport available, organised on request from the transport manager. Resident have access to a General Practitioner, along with allied health supports such as physiotherapy, occupational therapy, psychology, psychiatry, social work, dietary services and sensory support. Residents are supported by a team of staff nurses and care assistants and the centre is managed by a full-time person in charge. The staffing whole-time-equivalent is 4 nurses, and 16.04 health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
28 November 2019	09:05hrs to 16:30hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

Residents living in this designated centre communicated through alternative methods. The inspector spent time in each bungalow of the designated centre and met all residents living there.

The inspector observed that residents were supported in a kind and person-centred manner. Staff demonstrated that they knew residents well, including their likes and dislikes and preferences.

The inspector observed the daily routine in the designated centre throughout the day of inspection. Some residents attended appointments or social events in another part of the campus and other residents went out for walks. When residents appeared tired, or requiring a change of position they were supported to rest in their bedroom. Although residents' expressive communication was individual and required support, the inspector observed staff engaging with residents in a positive way, including them in conversations and seeking their responses.

Staff were respectful of residents' known preferences and ensured these were met. For example, dimming lights for residents with did not like the room overly bright, and positioning residents who used wheelchairs in a way that included them in the group or gave them a more stimulating view.

During the inspection, residents observed staff beginning to put up the Christmas decorations in preparation for the holiday season. Residents were included in conversations and plans to attend festive events. For example, to visit a lights show in Dublin Zoo. Throughout the day, residents were often offered tea, coffee or other drinks. As this designated centre did not have a separate staff office, there was opportunities for staff and residents to sit together and discuss the day over a cup of tea or coffee, this promoted a more inclusive atmosphere and better opportunities for residents to be involved in conversations and decisions about the centre.

The inspector observed that the premises were fully accessible for residents, with ample space for residents to spend time together in communal rooms. Residents individual bedrooms were uniquely decorated to suit their tastes or preferences, and each bedroom had space for visitors to sit and spend time with their relatives or friends.

The inspector observed any visitors to the centre (such as household staff or maintenance members) knocking or ringing the door bell and speaking with residents and staff before carrying out their tasks. Some residents appeared to enjoy the social interactions from visitors.

The inspector observed meal time in the designated centre. While food was prepared and cooked in a central kitchen, it was heated for a period of time in

the designated centre prior to serving which offered a nice smell of food in advance of the meal. In general, residents sat together with the support of staff for their main meals and almost all residents required one staff to support them to eat. However, in one bungalow due to the staffing available, one resident was required to wait for their meal, and there was not enough staff at this time to give all residents the one to one support that they required.

The inspector saw that this designated centre had its own wheelchair accessible bus, and there were a number of drivers on the staff team who could use this resource daily.

The inspector observed that there was a vacant bedroom on the day of the inspection, and a vacancy for one registered bed. The inspector observed that staff were kept busy throughout the day attending to the needs of the current residents, who at times required two staff or one staff to support them with personal care, or other activities of daily living. Should the current vacancy be filled, the provider would be required to assess for the requirement of additional staff support to maintain a good standard of care and support for all residents.

Capacity and capability

This was the first inspection of the newly configured designated centre consisting of two homes, which had previously been apart of a larger designated centre on campus. This inspection found that the provider and person in charge demonstrated capacity and capability in operating and managing a service that was safe and meeting residents' health needs in a homely environment. While some areas were in need of improvement, overall it was demonstrated that the centre was being managed in a way that resulted in substantial compliance with the regulations and standards. The re-configuration of these two homes as one registered designated centre was impacting positively on the oversight arrangements, the monitoring and review of the care and support being delivered and the lived experience of residents.

There was a clear management structure in place in the designated centre, and the wider organisation with effective lines of reporting and accountability. There was evidence of effective oversight arrangements in place in the designated centre by the person in charge and staff nurses, with clear allocations of duties and responsibilities. Actions identified through audits, reviews or residents' meetings were seen to be followed up and reviewed. The person in charge met regularly with the programme manager to review the designated centre and there were clear lines of information and escalation of issues to both the Acting Director of Nursing, Acting Director of Care and the executive management team. Issues that were brought to the attention of the provider by the local management team were in line with the findings of this inspection. For example, in relation to staffing issues and residents' general welfare and development. The programme manager reported to a care management meeting on a routine basis regarding any incidents, escalating risks,

safeguarding concerns or staffing issues in relation to this designated centre.

The provider had implemented governance oversight systems and processes in order to monitor and improve the quality and safety of care and support across the designated centres. An annual review had been completed by the provider along with six-monthly visits which generated a report and action plan. This designated centre was due a six-monthly unannounced visit in September 2019 which had not yet taken place.

The registration of this designated centre included one restrictive condition with a purpose to ensure that the provider adhered to a written improvement plan to demonstrated how they would continue to improve the lived experience of residents over the course of 2019. On review of this document during the inspection, the inspector found that a number of local actions had been achieved by the person in charge in line with the actions and time-lines as outlined in this plan. For example, residents' house meetings and monthly key-worker meetings with residents were occurring, residents' communication supports had been identified and put into plans, residents' activities and goals were being reviewed regularly and residents' annual health check-ups were completed or scheduled as planned.

Some actions within the written plan had not yet been fully achieved. For example, the provider had not ensured all staff were trained in risk and incident management within the time-frame indicated, and due to a reduction in staffing and resources it was proving difficult for staff to prepare and cook meals within the designated centre.

The registered provider had not ensured that the number of staff available to support residents each day was in line with the assessed needs of residents and the statement of purpose. Since July 2019, the staffing numbers on duty each day in the designated centre had been reduced. This reduction was based on a dependency assessment completed by the provider. While staffing ratios appeared favourable with six staff on duty each day to support seven residents, on review of residents' individual needs the staffing available was not always sufficient. For example, all residents required two staff to support them with personal care or manual handling, and almost all residents required one to one support at mealtimes or to attend activities outside of the designated centre. The inspector observed some residents waiting for their main meal, as there was not enough staff to give each resident the individual support they required so that residents could dine together.

In addition to the reduction of staff since July 2019, the inspector found that in the month of October there were 21 days were the staffing numbers were below the required amount of six, this was due to sick leave absences. Given the restrictions on the person in charge to replace staff who were on leave, and the high needs of residents, this was in need of address by the provider to ensure adequate staffing was put in place to meet residents' needs in place of a resource-led approach to the management of the designated centre. At the time of the inspection, the designated centre had seven residents and one vacancy. The inspector was not assured that if the designated centre was at full capacity, that all residents would receive the same standard and quality of care they were receiving within the current

staffing allocations. From review of records, it was evident that a number of activities or planned events had not gone ahead for residents due to the failure of the provider to cover unplanned leave during the previous months.

While the staffing resources were in need of address by the provider, the inspector found that the staff team were promoting meaningful activation and social inclusion for residents as best they could. In recent weeks a wheelchair accessible vehicle had been donated to the designated centre, and this had increased residents access to community activities. Staff were observed to be eager to offer residents meaningful days and interactions between residents and staff were friendly, respectful and person-centred.

There was a system in place in the designated centre to monitor training of staff in key areas such as fire safety and safeguarding vulnerable adults. While there was good oversight of these training needs by the person in charge, some mandatory training was in need of refreshing for a number of staff at the time of the inspection. For example, two staff required refresher training in safe manual handling. While there was an agreed list of mandatory training for the organisation, required training based on the specific needs of the residents in this designated centre had not been fully considered. For example, training in dysphagia (swallowing difficulties) was not identified as mandatory for the staff team even though all residents in this designated centre required modification to their food in order to reduce the risk of aspiration or choking. The acting director of care informed the inspector that a review was being completed to identify mandatory specific training for each individual designated centre going forward. The provider had outlined in their written improvement plan that staff would received training in risk management and incident management by June 2019. While some staff members had completed this, not all staff had. There was a formal system of staff supervision in place in the designated centre along with regular and effective team meetings by the person in charge.

Overall, this inspection found that the re-configuration of these two homes from a large designated centre, into this smaller designated centre was having a positive impact on the provider and person in charge's capacity to operate the service in line with residents' needs. Residents were provided with an accessible and safe place to live, with good oversight of their care and support needs. Some improvements were required however, to ensure the staffing resources available were in line with residents' assessed needs and to ensure residents were in receipt of a good quality of life and improvements could be sustained and progressed.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff on duty in the designated centre was in line with the number and assessed needs of residents, most notably at times of unexpected staff leave.

This designated centre had a staff team of nurses and care staff to support

residents. For the most part, nursing care was available within the designated centre on a daily basis, with the person in charge available to cover any nursing requirements.

There was a stable and consistent staff team available to work in the designated centre, and staff knew residents well and some had supported residents for a number of years.

The person in charge had ensured a planned and actual staff roster was maintained in the designated centre to reflect the staff on duty during the day and night time.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While the provider had arrangements in place for staff in the designated centre to access training, including refresher training,not all staff had up to date training in mandatory areas as identified in the provider's own policies.

For example, out of 24 staff members:

- Two staff required refresher training in safe manual handling

- Six staff required refresher training in fire safety

- Four staff required refresher training in safeguarding vulnerable adults

- Not all staff had completed risk and incident management training as per the provider's written improvement plan.

While agreed mandatory training was identified for the organisation, there were additional training requirements specific to this designated centre that had not been completed. For example:

- staff did not received formal training in dysphagia or the modification of food

Staff working in the designated centre were appropriately supervised, both informally and formally through recorded one to one meetings with the person in charge or staff nurses.

Information on the Health Act 2007 (as amended), regulations and standards were available in the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear governance structure in place in the designated centre, along with defined lines of reporting, responsibility and accountability.

There were effective management systems in place to monitor the safety and quality of the care and support in the designated centre. An annual review had been completed and a schedule of six monthly visits was in place. However, a six-monthly visit on behalf of the provider was now over-due.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a written statement of purpose and function for this designated centre which was in line with the requirements of schedule 1 of the regulations. The statement of purpose was found to be a true reflection of the services and facilities that were available to residents on the day of the inspection.

Judgment: Compliant

Quality and safety

This inspection found that residents were in receipt of a service that was safe, quite person-centred and meeting their individual needs. That being said, the manner in which the provider had resourced the centre had some negative impacts on the opportunities for residents to engage in more activities in line with their needs and preferences. Some improvements were required to promote the quality of care and support through improved assessment and planning tools and increased access to meaningful activities.

Residents' interests and preferences were recorded and known by the staff team that supported them. From review of residents' records the inspector found that residents had opportunities to spend time doing things that they enjoyed both within the campus, and off the campus in the local area or further a-field. For example, the inspector spoke with staff and saw some photographs of residents enjoying trips to Belfast and visiting museums. Residents were supported to attend mass, local pubs and coffee shops, shopping centres and cinemas. On the day of inspection, staff were planning some festive events for residents in the lead up to Christmas such as music performances. Some residents took part in activities on campus such as feeding chickens, going for walks and party events in the big hall. While residents

had opportunities to take part in activities that were meaningful to them, there were a number of occasions in the previous months where planned activities had not taken place due to limited staffing resources. This resulted in residents spending days at home, in place of their planned activity. The manner in which the provider was managing the staffing resource in the designated centre, was limiting residents opportunities for recreation.

While residents were often supported to shop for food supplies in the designated centre, residents were not supported to participate or observe the preparation and cooking of meals in their home. Meals were provided by a central kitchen, and re-heated in the designated centre. Staff told the inspector that occasionally at weekends meals or home baking was done, which residents appeared to enjoy, but it was dependent on staffing available.

Some residents required a modified diet to reduce their risk of choking or aspirating food. Food choices available from the central kitchen were not always conducive to easy or quick modification, and often in order to ensure safe modification of prepared food, meals were presented mixed in one bowl without clear identification of what was being eaten. As staff did not prepare and cook the food in the centre, there were a number of steps involved in ensuring pre-made food was in line with residents' needs.

Due to the amount of staff available, not all residents could eat together at mealtimes and some residents had to wait for assistance when other residents had finished their meals. When residents were supported with their meals, it was observed that mealtimes were kept quiet, and residents were supported at a pace that suited their needs and preferences. Equipment and aids were available should residents require them, such as specially adapted spoons or cups. On arrival to the designated centre in the morning, the inspector found the dining table was nicely decorated with place settings and napkins. Residents were offered tea, coffee and drinks throughout the day, there was fresh fruit in the dining room and the designated centre was stocked with adequate food supplies for both main meals as well as snacks and lighter meals.

The provider had a risk management policy in place which was available in the designated centre, and the person in charge maintained a risk register which identified all known risks for residents and the centre in general. Staff were familiar with the risks and their control measures and in general risk within the designated centre was low, and well managed through appropriate staff support and intervention. The provider had carried out an audit on risk in April 2019 which found that risk was being managed in line with the provider's risk management policy. There were escalation pathways in place to ensure any increase in incidents, newly identified risks or an increase in risk overall was brought to the attention of the executive management team and provider. While risks in general were low, and there were low frequency of adverse events, the provider had not ensured that all control measures were considered for the management of the risk of choking and aspiration. For example, as mentioned earlier staff had not completed formal training in dysphagia. The speech and language therapist had assessed all residents, clear care plans and supports were in place and guidance on the thickening of fluids

had been given to staff. However, a more practical training was required, along with a review of how meals were prepared in order to support staff further.

The provider had put in place adequate processes to promote residents safety and protect residents from harm. There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions and the process for responding and recording safeguarding concerns was in line with national policy. Residents had access to a social work department, if required and there was a named designated officer for the designated centre. Since registration of this centre, two alleged safeguarding incident had been recorded and notified to HIQA (Health Information and Quality Authority), and the safeguarding team as per national policy. The inspector found that incidents was screened and responded to appropriately, a safeguarding plan was put in place and additional control measures were implemented to prevent a similar situation from happening again. Where residents were at risk of bruising easily due to the side effects of medicine or health issues, there were risk assessments and care plans in place to address this. Staff were knowledgeable on their duties to respond and report any safeguarding concerns and had been provided with training. Some staff required refresher training in safeguarding vulnerable adults. Overall, the inspector found that there were strong safeguarding process in place in the designated centre, with clear recording and review of incidents to ensure measures were taken to protect residents from harm.

Some improvements were required with regards to residents' assessment of needs and personal planning. Residents' health care needs were assessed and planned for, information was kept up to date and for any assessed health-care need there was a corresponding plan in place to support it. Staff met with residents on a monthly basis to determine what social goals they wished to work on for the month, and there were also longer-term goals being actively worked on with residents. However, there was an absence of a formal system of assessing residents' personal and social needs in order to maximise their opportunities for new experiences and personal development. The provider had outlined in their site visit response that a new assessment tool would be put in place by June 2019. These were not yet in place at the time of inspection, and the inspector was informed that this was in development currently with plans for the new assessment to be put in place in January 2020. This would guide staff in identifying residents' individual needs in a more holistic manner.

Residents had access to their own General Practitioner (GP), and access to this service had improved recently through the introduction of an assessment system prior to an appointment. Residents had access to a range of allied health professionals employed by the provider such as psychology, occupational therapy, clinical nurse specialists and physiotherapy. The person in charge and staff nurses had good oversight of residents health care needs, and there were links with external teams such as palliative care.

Overall, the provider and person in charge were promoting a service that was safe and of good quality, however further improvements were required in relation to residents' assessments, control measures to reduce risk and access to meaningful activities.

Regulation 13: General welfare and development

While residents had opportunities to take part in activities that were meaningful to them, this was somewhat limited by the resources available in the designated centre.

While residents were supported to develop links with the wider community by the staff team, this was dependent on adequate resources being put in place by the provider each day.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Meals were provided by a central kitchen, and re-heated in the designated centre. While residents were often supported to shop for food supplies in the designated centre, residents were not supported to participate or observe the preparation and cooking of meals in their home.

The manner in which meals were provided, was somewhat limiting staff's ability to safely prepare and serve food in line with residents' assessed needs.

Due to the amount of staff available, not all residents could eat together at mealtimes and some residents had to wait for assistance.

Residents were supported at mealtimes in an appropriate manner.

Equipment and aids were available should residents require them.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had written and implemented a risk management policy in the designated centre which met the requirements of the regulations.

The provider had carried our an audit in the designated centre, to assess if this policy was being followed and risk was managed.

There was good oversight of risk through a well maintained risk register and risk

assessments, and there was an escalation pathway in place.

Control measures in place, were not found to be overly restrictive and were proportionate to the risks identified.

Some improvements were required in relation to training to support staff to further manage some risks.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' healthcare needs were assessed and planned for in the designated centre. Assessments were multidisciplinary, and advice from allied health professionals was included in healthcare plans.

Residents' social and personal needs were being actively worked on by the staff team, however there was an absence of a comprehensive assessment of residents' needs to continue to guide the care and support.

Residents personal plans were not in an accessible format.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a General Practitioner (GP) and a multidisciplinary team which consisted of a psychiatrist, psychologists, occupational therapist, physiotherapist, speech and language therapist, clinical nurse specialist in behaviour, social workers and dietitians. Residents also had access to dental services, optician services and chiropody services.

Judgment: Compliant

Regulation 8: Protection

There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions and the process for responding and recording safeguarding concerns was in line with national policy.

The provider had appointed a designated officer to the designated centre to ensure

all safeguarding incidents were responded to and investigated, and residents had access to a social work department if required. Residents had intimate care plans in place to guide their needs and preferences.
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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 17 OSV-0005851

Inspection ID: MON-0027121

Date of inspection: 28/11/2019

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The number of staff in the designated centre was reviewed at the Dependency Needs Assessment Review Group on 4/12/19 to ensure that the numbers of staff in the designated centre is sufficient to provide a safe service. Where an individual's needs changes, a business case will be developed and submitted to the Director of Care-Residents for the Director of Care-Residents to review and submitted to the HSE for approval. 2. Should the current vacancy be filled, an assessment will take place to assess for the requirement of additional staff support to maintain a good standard of care and support for all residents	
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. Where staff require refresher training, this will be provided. 2. Risk training will be provided for all staff. 3. Centre specific training will be explored, including formal, practical dysphagia training will be sourced and provided	

Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. A six monthly review of the centre will take place	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: 1. A review of the access to recreation facilities on campus will take place with a view to reopening services. 2. A review of staffing levels will take place to consider residents access to activities in accordance with their interests, capacities and needs. 3. Resident's opportunities for accessing activities of their choice and preference shall be recorded and reviewed by the Person in Charge with targets measured against key performance indicators. These shall be reviewed at monthly team meetings (31/01/2020).	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: 1. A review of meals in the home received from the central kitchen will take place to ensure that the choices offered are the most suitable for residents and can be appropriately modified to meet residents needs 2. A review of staffing levels will take place to consider residents needs in line with the comprehensive assessment of need	
Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. Risk assessments will be reviewed to ensure they capture staff training requirements	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. Information sessions will take place for the new assessment of need 2. An assessment of need will be carried out with the resident and from this a personal plan will be developed. 3. The personal plan will be reviewed at a multi-disciplinary team meeting, at least once per year.	

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/01/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	28/02/2020
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Substantially Compliant	Yellow	30/12/2019

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2020
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Substantially Compliant	Yellow	28/02/2020
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	31/01/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Substantially Compliant	Yellow	31/01/2020

	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.			
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.	Substantially Compliant	Yellow	31/01/2020
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual	Substantially Compliant	Yellow	31/03/2020

	basis.			
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/03/2020