Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Regulation of Health and Social Care Services

Overview of inspection and monitoring activity in Stewarts Care Limited 2017-2018

March 2019

Safer Better Care

About the Health Information and Quality Authority (HIQA)

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children and Youth Affairs, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Office of the Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

About the regulation of centres for people with disabilities

The Office of the Chief Inspector of Social Services in the Health Information and Quality Authority (HIQA) regulates designated centres to safeguard vulnerable people of all ages who are receiving residential care services in designated centres.

Regulation assures the public that people living in a designated centre are receiving a service that meets regulations and strives to reach National Standards. Regulation also promotes and protects the health, wellbeing and quality of life of people in residential care.

Regulation also has an important role in driving continual improvement so that residents have better, safer lives.

The Office of the Chief Inspector has, among its functions under the Health Act 2007 (as amended), responsibility to regulate the quality of service provided in designated centres for children and adults with disabilities.

Regulation has two principal aspects:

1. **Registration:** under section 46(1) of the Health Act 2007 (from here on referred as 'the Act') any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
2. **Judgment of compliance:** the purpose of inspection and related regulation is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and its compliance with the Act, regulations and operating conditions.

On-site inspections take place to assess continuing compliance with the regulations and National Standards, and they can be both announced or unannounced. Unannounced inspections may take place at any time of day or night. The Office of the Chief Inspector may inspect designated centres:

- to assess compliance with regulations and National Standards
- following a change in circumstances in the centre, such as:
  - the appointment of a new person in charge
  - arising from a number of events, including information affecting the safety or wellbeing of residents.

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1. Executive Summary

Introduction

Over a two-year period from 2017 to 2018, the Office of the Chief Inspector of Social Services within the Health Information and Quality Authority (HIQA) deployed a range of measures to improve residential care services for residents in centres provided by Stewarts Care Limited, mostly at its campus in Dublin.

Between June and August 2017, the Chief Inspector proposed cancelling the registration of six designated centres for people with disabilities operated by the registered provider, Stewarts Care Limited, in response to ongoing serious failures to meet regulations.

In order to drive improvement in the services provided for residents, inspectors undertook a range of regulatory actions aimed at ensuring the provider improved its oversight of the services and that this improved oversight resulted in real improvements in the quality of life for residents.

Incremental improvements in the safety and quality of life for residents has since been achieved. However, an improved quality of life for residents has not yet been consistently implemented across all of the services.

This report summarises the escalated regulatory programme in services operated by Stewarts Care Limited in 2017 and 2018. The report includes a summary of the findings from the initial inspections in 2017, improvements in some aspects of the service that were found on later inspections in 2018, and the further improvement in the quality of life for residents which was found when inspectors visited the centres to speak and spend time with residents during September 2018. The purpose of these visits was to identify whether the changes being made by the provider were resulting in real improvements in the quality of life for residents.

HIQA acknowledges that changing the culture of services with historical cultural issues takes time. Inspectors will continue to maintain close oversight and promote ongoing improvement for residents in these services and their families.

Background to the regulatory approach

From May 2017 to July 2018, 16 announced and unannounced inspections were carried out in eight designated centres operated by the provider. Overall, inspectors[◇] had found a poor quality of service was being delivered to 160 residents, and the

[◇] Inspections of designated centres were carried out by inspectors of social services in the Office of the Chief Inspector within HIQA.

registered provider was failing to make adequate improvements to the service at that time.

Significantly high levels of non-compliance with the regulations and National Standards were found — in particular, relating to key areas such as governance and management; healthcare; safeguarding and safety; residents' rights, privacy and dignity; workforce; and the suitability of the premises. These findings were set out in a number of inspection reports which were published on HIQA's website in 2017 and 2018. A full list of engagement between inspectors and Stewarts Care Limited is detailed in Appendix 1 of this report.

Overall, inspectors found that:

- a significant number of residents were receiving a poor quality service
- the provider had failed to make improvements that they committed to implement following previous inspections
- the provider was failing to:
  - — effectively monitor the centres and
  - — identify and address the significant deficiencies in the services it provided to residents
- where improvement initiatives had been put in place in 2017 in some centres, the provider had not implemented these improvements across all the centres.

After these inspections, statutory notices of proposal to cancel the registration of two of these six designated centres on 6 June 2017 were issued, and statutory notices of proposal to cancel the registration of the remaining four centres on the campus were issued on 9 August 2017.

In such circumstances, the Health Act 2007 (as amended) allows providers to make representations to the chief inspector within the set time frame of 28 days. In this case, the provider of Stewarts Care Limited responded with a representation outlining its plan to improve the quality of life for residents and to bring the centres into compliance with the regulations.

Inspectors completed a further series of inspections in December 2017. These found that while there had been some improvements, the provider continued to fail to meet regulations and this continued to adversely impact on the safety and wellbeing of residents.

Furthermore, during this time, inspectors found similar levels of regulatory non-compliance in two separate community-based centres operated by the registered

provider in Dublin. In light of concerns for residents' wellbeing in all eight centres, the provider was asked to attend a meeting at HIQA's offices in Dublin.

On 8 January 2018, the registered provider, Stewarts Care Limited, met with the Deputy Chief Inspector (Disability), the regional manager and with inspectors to discuss the overall findings from these inspections. During this meeting, the registered provider accepted that all residents were not receiving the quality and safety of service to which they were entitled.

In acknowledging this, the registered provider outlined its plan to restructure and improve the overall governance arrangements of the organisation. In addition, it provided assurance that these changes would improve the quality of the care and support it provides to all residents.

The registered provider stated that the competencies of its board of directors had been reviewed and enhanced. New directors had been appointment and a board subcommittee to oversee the management of risk, safety and quality was established.

In addition, it reported that operational management structures and arrangements had been reorganised to include defined roles and staff accountability in the designated centres. At this meeting, the Deputy Chief Inspector emphasised the gravity and seriousness of the regulatory failings.

Following this meeting, the provider was required to submit a six-month improvement plan to the Chief Inspector, with key, measureable milestones to ensure that day-to-day and longer term quality-of-life outcomes for residents were improved.

In order to drive improvements in the services, inspectors undertook an escalated regulatory programme of Stewarts Care Limited, over and above routine monitoring of the service, which included:

- requiring the provider to submit a monthly status report on the implementation of its improvement plan and
- monthly meetings between the provider and inspectors.

At these monthly meetings, which ran from January 2018 until June 2018, the registered provider reported that it was improving governance and management arrangements, and was improving safeguarding, healthcare, workforce and residents' rights, privacy and dignity.

Throughout this period, inspectors continued to inspect the centres in order to verify information given by the provider and to check whether the quality of life of

residents was improving. Inspectors spoke with and observed residents and staff to seek their views, experiences and opinions about what was happening in the services and how changes reported by the provider were affecting their lives. Inspectors also observed that the provider had, as of April 2018, closed all dormitories resulting in each resident having their own bedroom.

At the end of this six-month period, in June 2018, inspectors acknowledged that the provider was investing in the services and that a cultural change was underway in its services. There was also evidence that care was becoming more person-centred in most houses on the campus. However, inspectors also saw that care in some houses continued to be task-orientated and institutional in nature.

The original registration of the eight designated centres expired in January and February 2018, and as a final decision had not been made on their renewal, the provider continued to operate them legally under Section 48 of the Health Act 2007.

In order to verify that the provider's revised governance arrangements were having positive impact on the lived experience of residents, inspectors visited each of the eight designated centres to hear what residents had to say about the changes and to observe the quality of life for residents in the centres. Overall, inspectors found that the actions of the provider were positively impacting on the quality of life of residents in most houses across the eight designated centres.

It was clear that staff knew the residents and understood their verbal and non-verbal responses. Inspectors saw residents smiling in response to staff members and comfortable with the staff members who were attending to their support needs. Inspectors observed that residents were consulted about the care they received throughout these visits.

Residents who were able to speak with inspectors said that they had plenty of choice in relation to food in their homes, which was important to them. They said they loved living in their home and that staff were great. They told inspectors that they made their own decisions and choices, and saw the centre as their home. Others mentioned that while they got on very well with familiar staff, they would prefer if there was more consistency in staffing and less of a need for the provider to use temporary agency staffing.

This report summarises the escalated regulatory programme implemented by inspectors in services operated by Stewarts Care Limited in 2017 and 2018 promoted improved governance oversight of the services. The report includes a summary of the findings from the initial inspections, improvements in some aspects of the service that were found on later inspections, and the further improvement in the quality of life for residents which was found during visits conducted in September 2018.

Inspectors continue, in accordance with the Health Act 2007 (as amended), to maintain regulatory oversight across services provided by Stewarts Care Limited. In October 2018 the provider submitted applications to register newly reconfigured centres to the Office of the Chief Inspector. The provider intends to divide the current six centres on the campus into smaller centres, each with their own person in charge, in order to further improve management of the centres and drive sustained improvements for residents. At present, each application is being considered subject to a site visit by inspectors and a review of individual improvement plans for each new centre.

Since December 2018 inspectors have continued to inspect the centres. While there are still a number of houses that need further improvement, inspectors have found overall that the provider is implementing their improvement plans and that there are sustained improvements to the quality and safety of care for residents. The reports for these and other inspections will be published in the coming months.

2. Introduction

This report provides an overview of the regulatory programme completed by inspectors between June 2017 and September 2018 in relation to services provided by Stewarts Care Limited on its congregated campus and in two of its community-based centres in Dublin. The report has been developed using a number of sources of information, including:

- inspection findings
- provider responses to compliance plans
- communications between inspectors and Stewarts Care Limited (the registered provider) and
- reports submitted by the provider.

Stewarts Care Limited is a voluntary organisation that provides both community-based and campus-based residential care and support in Dublin and County Kildare to both adults and children with an intellectual disability. The services are funded by the Health Service Executive (HSE).

Stewarts Care Limited provides residential services on a campus in Dublin 20. There are 35 buildings on the campus. There were six designated centres on the campus, where 160 residents lived when this regulatory programme commenced, comprising of 25 houses and one apartment (a number of houses comprise each designated centre). In addition to the residential houses, the campus features a Health Service Executive (HSE) public health building, a library, special school, sports centre and swimming pool, and a restaurant. There are also administration and technical service buildings on the campus.

The organisation also has 10 community residential centres for 115 residents living in 29 houses. Two of these community-based centres feature in this overview report.

2.1 Overview of Stewarts Care Limited

Profile of the six campus-based centres

At the time of compiling this report, the six campus-based centres each had a person in charge, whose job title within the organisation was 'programme manager'. The provider has developed a reconfiguration plan for the campus, creating new centres which would each have a 'responsible person' who was similar to a local supervisor.

The provider has stated that these 'responsible persons' would become the persons in charge of these centres once the reconfiguration takes place. The provider has

applied to the Chief Inspector within HIQA to register reconfigured centres as part of its quality improvement plans. The Chief Inspector is continuing to assess these applications.

The following six centres are all campus-based designated centres which are full-time residential facilities for adults with intellectual disability many of whom also have complex health needs. One centre also provides residential services for children and another also provides respite care. The centres are:

Adults Services Palmerstown Designated Centre 1 — OSV-0003897

The centre is comprised of three bungalows and two 2-storey houses. It can accommodate 21 residents.

Adults Services Palmerstown Designated Centre 2 — OSV-0003899

The centre is comprised of one 2-storey house and four bungalows. It can accommodate 30 residents.

Stewarts Adults Services Palmerstown Designated Centre 3 — OSV-0003900

This is a centre for both adults and children with intellectual disability and complex health needs. The centre is comprised of one 2-storey house and four bungalows. It can accommodate 39 residents.

Adults Services Palmerstown Designated Centre 4 — OSV-0003901

This centre is comprised of three bungalows and one bungalow that is converted into four self-contained apartments. It also provides a residential service for adults with intellectual disability and complex health needs. It can accommodate 27 residents.

Adults Services Palmerstown Designated Centre 5 — OSV-0003902

The centre is comprised of two 2-storey houses and two bungalows. It can accommodate 30 residents.

Adults Services Palmerstown Designated Centre 6 — OSV-0003903

The centre is comprised of four bungalows. It can accommodate 30 residents.

Profile of the two community-based centres

The escalated regulatory programme featured in this overview report also includes two community-based centres in Dublin, each with its own person in charge. These are:

Stewarts Adults Services Palmerstown Designated Centre 7 — OSV-0003904

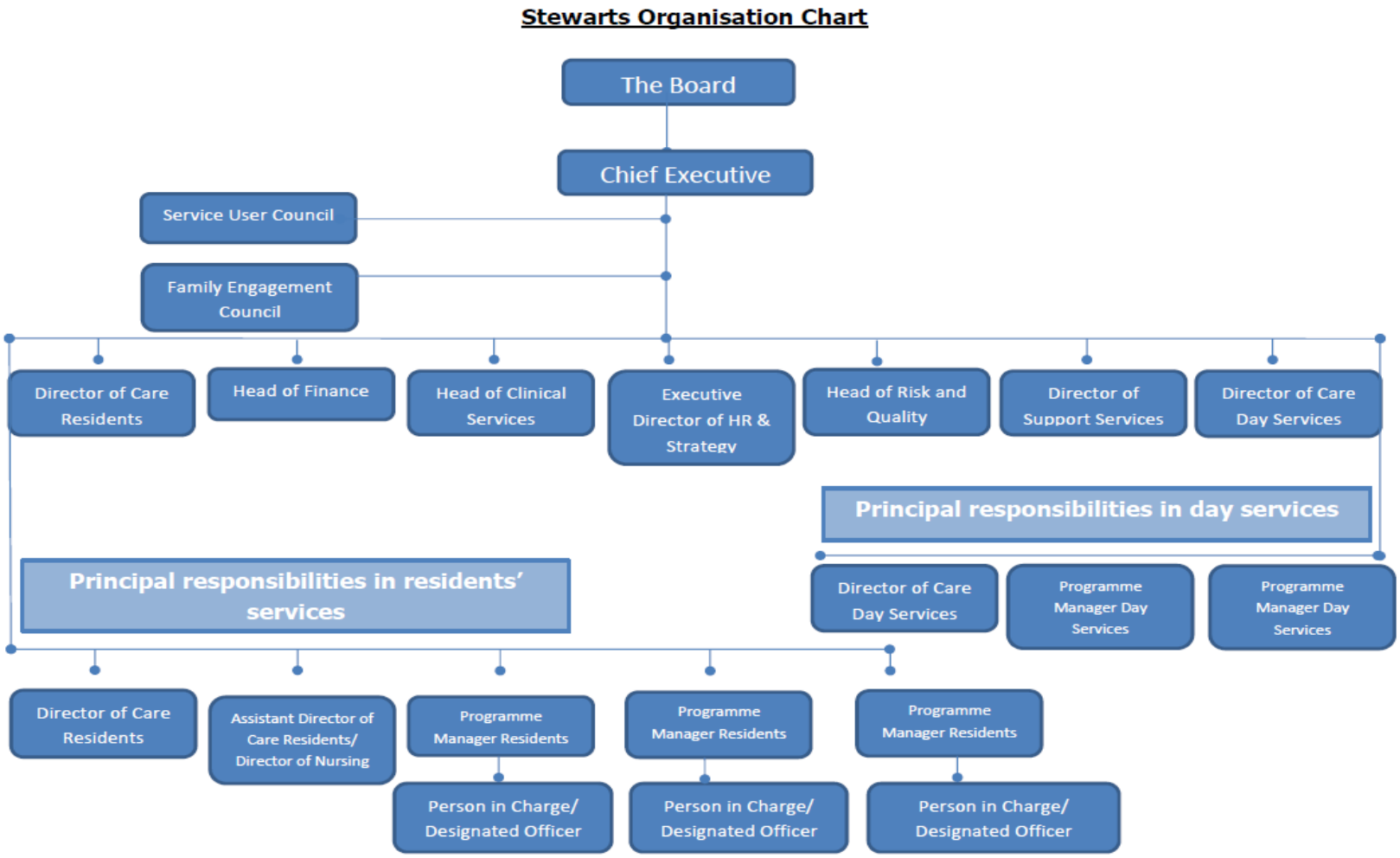
This community-based designated centre is a full-time residential facility for adults with an intellectual disability and varying health needs. The centre is comprised of one 2-storey house and 10 apartments. It accommodates 14 residents.

Adults Services Palmerstown Designated Centre 8 — OSV-0004103

This community-based designated centre is a full-time residential facility for adults with an intellectual disability and varying health needs. The centre is comprised of two 2-storey houses, one bungalow and a second-floor apartment. It accommodates eight residents.

The overall residential services are overseen and managed by a Director of Care (residents). The management structure for Stewarts Care Limited, at the time of writing this report, is outlined in Figure 1. The information in the organisational chart was provided to inspectors by the registered provider.

Figure 1: Stewarts Care Limited management structure



3. The regulatory programme

3.1. Assessment of the campus

Following inspections between May and July 2017 (see Appendix 1), which found poor regulatory compliance that was impacting negatively on the lives of residents, and failure by the registered provider to adequately respond to these non-compliances, the Office of the Chief Inspector within HIQA issued Stewarts Care Limited with statutory notices of proposal to cancel the registration of all six campus-based centres.

Inspectors also informed the funder of the services, the Health Service Executive (HSE), about its significant concerns.

In line with its legal entitlement as set out in Section 54 of the Health Act 2007, as amended (the Act), the provider submitted a representation to the chief inspector in response to these notices of proposal to cancel registration. In it, the provider set out the actions it was taking to improve the quality of the service to residents and to bring the centres into compliance with the Act, associated regulations and National Standards.

The provider was informed that a series of inspections would be undertaken to verify whether the actions it outlined in its representation were effective in improving quality of life for residents.

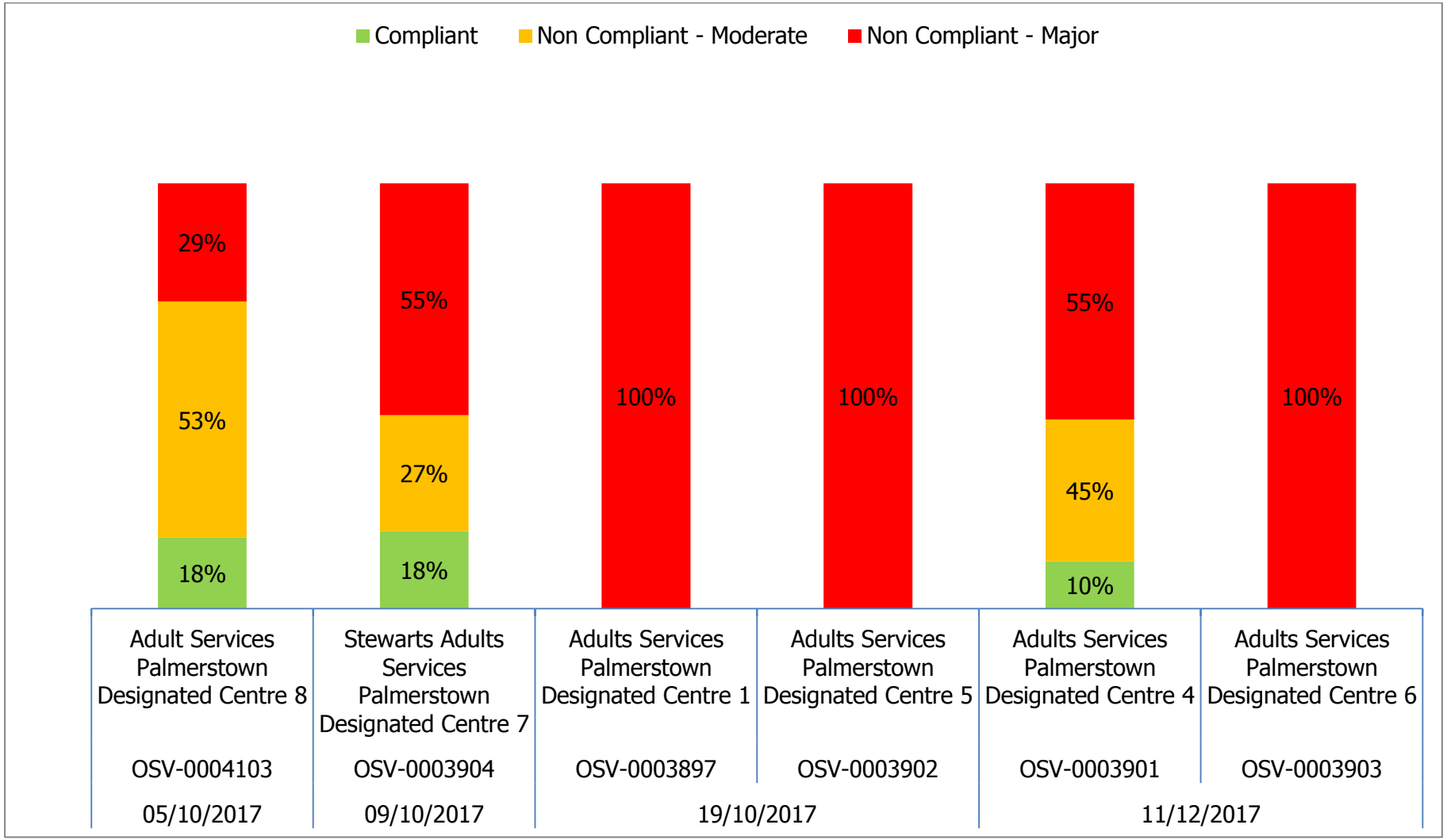
Between 5 October 2017 and 11 December 2017, inspectors carried out six further inspections, which mostly found poor compliance and an ongoing failure by the provider to demonstrate sufficient progress in improving the safety and quality of life of residents in the centres (see Chart 1). These reports are available on www.hiqa.ie.

During the inspection process, the provider was informed that its governance arrangements were poor, and that it was:

- failing to consistently self-identify significant shortcomings in the service to residents
- where inspectors identified issues, failing to take effective action to make sustainable improvements in the quality of life for residents.

The provider reviewed its governance arrangements from the level of board of directors to local management level and was required to submit an improvement plan to the chief inspector.

Chart 1.Levels of non-compliance of six inspections carried out between 5 October 2017 and 11 December 2017 of Stewarts Care Limited



The provider was required to attend a meeting at the HIQA offices in Dublin on 8 January 2018 to discuss its improvement plan and how Stewarts Care Limited would ensure that progress was achieved over a six-month period.

The provider reported recent changes to the competencies of its board of directors, including the appointment of a new chair and new directors. The provider also spoke about its rejuvenated subcommittees of the board, set up to provide oversight of key areas including risk management and quality improvement.

They also said that independent auditing of the quality of the services was being undertaken by an external, independent organisation which was reporting directly to the Chief Executive Officer. The provider stated that the purpose of these improvements was to implement more effective governance of the services and ensure improved quality of services to residents.

The provider set out how it would undertake monthly audits of the implementation of the improvement plan and its impact on the quality of service provided to residents. The provider outlined five key areas which its assurance report would assess:

- residents' rights, privacy and dignity
- safeguarding
- healthcare
- staff competency and knowledge
- oversight of the implementation and effectiveness of their improvement plan.

In response to the six-month improvement plan and to afford the provider time to implement these improvements, inspectors developed a regulatory schedule to:

- monitor the implementation and effectiveness of the provider's plan
- assess compliance with regulations and National Standards through a schedule of inspections
- continually monitor the service through the review of solicited and unsolicited information received, in addition to reviewing notifications.

In order to monitor the implementation and effectiveness of Stewarts Care Limited's plan, inspections were carried out in four centres throughout the six-month period; one each in February 2018, April 2018, May 2018 and July 2018, see Chart 2.

While these inspections demonstrated some improvements in compliance with the regulations and National Standards, there remained significant levels of non-

compliance. Inspectors found that while there was some improvement to the quality of life for some residents, it was inconsistent across the four designated centres inspected (see Chart 2).

The provider was required to attend a further meeting on 22 August 2018 at HIQA's Dublin offices. At this meeting, while acknowledging that some improvements had been made, the Deputy Chief Inspector (Disability) communicated dissatisfaction with the progress made to improve outcomes for residents.

The provider was informed at this meeting that, prior to giving consideration to the registration of the centres, inspectors would visit each of the centres to speak with residents and to observe the quality of their life in each of the centres.

On 5 and 13 September, inspectors spent time in all of the houses, observing residents' lives and speaking with residents who consented to engaging with them. Inspectors wanted to ascertain whether residents were being supported to live a more meaningful life.

Overall, inspectors found that, for many residents, there was a marked improvement in their quality of life and their physical environment. However, positive change had not occurred to the same extent for other residents.

Since those visits, inspectors have undertaken further inspections which have confirmed that improvements for residents have been sustained, and the reports of these inspections will be published on the HIQA website in the coming months.

3.2. Stewarts Care Limited assurance reporting

As part of the improvement plan for the centres, the provider was required to submit an assurance report to the Regional Manager in HIQA on a monthly basis during the six-month escalated regulatory programme.

The provider outlined five key areas for improvement. These were:

- residents' rights, privacy and dignity
- safeguarding
- healthcare
- staff competency and knowledge
- governance and management, including monitoring of its own improvement plan.

In addition, the provider's Director of Care (residents) met with a regional manager from HIQA on a monthly basis between January and June 2018 to discuss progress

and to provide more information on the details of the work being undertaken by the provider.

Separately, the Chief Executive Officer (CEO) of Stewarts Care Limited submitted information to the Deputy Chief Inspector (Disability) outlining actions that were being implemented to improve governance and operational arrangements, which included:

- the provider identifying in its strategic plan a goal to move, as part of a transition process, 25 people out of the campus and into more appropriate, community based houses annually in consultation with residents and their families
- the provider committing to no further admissions to the campus-based congregated setting
- a new complaints committee being set up from July 2018 to be chaired by a member of its board of directors
- new personnel being appointed to the service, which included the appointment of:
    - a new clinical nurse specialist in behavioural support in October 2017
    - a new head of clinic and a senior psychologist in April 2018
    - a new director of support services and a new transport manager in July 2018
- arrangements to support best practice, which included:
    - a new behavioural support policy
    - plans for the design and implementation of an educational module for nursing staff on nutritional screening
    - plans to design and develop resource packs to support the provider's nutrition and hydration policy
- improving staff knowledge through training, which included:
    - developing and commencing training on a new training module in positive behavioural support in April 2018
    - delivering 16 training sessions on the use of a nutritional risk-screening tool between 23 July 2018 and 8 August 2018

- designing and implementing a two-day training course in risk management for all managers
- designing and implementing a one-day training course in practical and effective risk assessment and management for all staff
- offering a three-day QQI (Quality and Qualifications Ireland) Level 6 course in people management to all persons in charge and responsible persons in the last quarter of 2018
- delivering a three-day training course run by an external organisation on 'Regulation in context' to all persons in charge and responsible persons in September 2018.

The CEO of Stewarts Care Limited also reported that the provider was in the process of recruiting a new head of risk and quality, an advanced nurse practitioner in dementia care and a clinical nurse specialist in epilepsy care. At the time of writing this report, the appointment of a new head of risk and quality has been made.

The provider also set out its plans to reconfigure the current six centres on the campus into 19 centres as a means to improve oversight and management of the support and care that was being provided to residents. The provider said this would increase oversight of the care and support delivered to residents, with a person in charge responsible for a smaller numbers of residents and less houses.

Inspectors found the management structure had also been further strengthened with clearer lines of responsibility and reporting, as outlined in the organisation's chart earlier in this report.

4. Summary of findings from inspections and visits

4.1 Summary of inspection findings: May 2017 to July 2018

The following section of this report sets out a summary of the findings of the monitoring inspections which were completed in 2017 and 2018. Detailed findings from these inspections are contained in inspection reports published on HIQA's website — www.hiqa.ie.

4.1.1 Outcome 14: Governance and management

Overall judgment

The provider had taken significant action to improve the management structures at senior level and in the designated centres. Improved processes, policies and systems were emerging. However, further significant improvements were required in relation to the provider's ability to effectively self-identify and monitor the safety and quality of the care and support delivered across all eight designated centres.

To improve governance, the provider had appointed 'responsible persons' to houses within the designated centres, with a view to those staff becoming persons in charge (the managers) of these houses when they were reconfigured into designated centres. Some of the improvements found during the 2018 inspections were dependent on the ability and drive of individual 'responsible persons' and had not yet been bedded in as part of the overall culture and oversight of the centres.

Overall, the actions taken by the senior management team and the provider were beginning to change the way that the services were being governed. However, further significant improvements were required to ensure that the improvements were consistently achieved across centres and sustained for all residents.

Governance and management — summary of 2017 inspections[1]

The 2017 inspections found that the lines of reporting and accountability were unclear to staff, residents and families alike. The provider's own monitoring systems were inadequate and failed to effectively identify and respond to issues impacting negatively on the safety and quality of life for residents. Overall, the provider had failed to effectively monitor the services, learn from information gathered and bring about positive changes for the benefit of residents.

[1] Inspection findings from inspections after the issuing of the statutory notice of proposal.

Governance and management — summary of 2018 inspections[2]

The inspections conducted during the implementation of the provider's improvement plan in 2018 found that while changes were being made to the management arrangements, deficiencies remained in the arrangements for ensuring that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

Changes in the management structure included the appointment of 'responsible persons', who were similar to local supervisors, across the residential houses who reported to the person in charge of the designated centre.

While there were stronger management structures in place and an emergence of improved processes and systems, there was evidence of inconsistency in the effective monitoring of the quality of service across the campus. Unannounced provider-led reviews of the centres (as required by the regulations) were inconsistent, as not all houses in the designated centre were reviewed and the quality of their findings differed.

Actions that arose from unannounced provider visits to the centres were not being completed in a consistent manner and the provider could not demonstrate that these reviews were positively impacting on the quality of care being delivered in all houses across the eight designated centres.

4.1.2 Outcome 8: Safeguarding and safety

Overall judgment

During the 2018 inspections, inspectors found that the provider had made improvements to safeguarding arrangements on the campus. These actions had improved the identification, reporting and response to safeguarding issues, including peer-to-peer altercations.

There had been an increase in the number of designated safeguarding officers in the centres, and the provider had improved the provision of safeguarding training to staff.

However, these improvements were not consistently implemented across all houses on the campus, with some centres demonstrating stronger safeguarding measures than others. Improvements had been noted in staff knowledge and training in arrangements to protect residents from risk of harm on a daily basis. Nonetheless, some of the houses in the designated centres continued to have issues in relation to

[2] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

the numbers of residents living together and their compatibility. This, at times, resulted in residents having negative experiences because of their interactions with other residents. The provider had plans to further reduce the number of residents in these houses which would improve the available living space for residents and promote residents' safety.

Management of restrictive practices was changing in the centres. In 2018 the provider was increasingly identifying and monitoring these practices in a more structured way. There had been changes in the policies and procedures, along with newly appointed members of the clinical team such as a clinical nurse specialist in positive behaviour support. These changes were beginning to positively impact on the supports provided to residents in relation to behaviours of concern. However, further improvements were required to ensure the safeguarding systems were consistently implemented and were bringing about improved quality of life for all residents.

Safeguarding and safety — summary of the 2017 inspections[3]

With the exception of one designated centre which was found to be compliant in relation to safeguarding and safety in 2017, the inspections carried out in the latter part of 2017 found that appropriate measures had not been implemented to protect residents from harm or abuse.

Appropriate action was not being taken in response to allegations or suspicions of abuse in the designated centres. The majority of staff had not been provided with up-to-date training in the protection of vulnerable adults and were found by inspectors to have poor knowledge on what constituted abuse and the appropriate actions to take if abuse was suspected or witnessed. Incidents that met the definition of abuse — as outlined by the *Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures* (Health Service Executive, 2014) — had not all been reported or responded to. Safeguarding plans for residents at risk were not consistently created, read or implemented by staff.

Inspectors found that there was widespread use of restrictive practices on the campus and these were not being managed in line with best practice. Inspectors found that there was poor understanding of what constituted restrictive practice and that many restrictive interventions were not being appropriately monitored. The implementation of specific restrictive interventions for some residents was having a negative impact on the rights of other residents living in the same environment and this had not been considered by staff or by the provider.

[3] Inspection findings from inspections after the issuing of the statutory notice of proposal.

Throughout these inspections, a number of residents were identified by staff as requiring additional support in relation to their behaviour. Inspectors found significant inconsistencies in the provision of this support across the campus. A number of residents did not have written plans in place to guide staff on how to support and respond to residents' behaviour.

Safeguarding and safety — summary of the 2018 inspections[4]

Overall, inspectors found improvements in the safeguarding arrangements on the campus. Despite these improvements, there continued to be inconsistencies in the implementation of good safeguarding practices to ensure all residents were protected from harm. Notwithstanding this, safeguarding incidents were being identified, recorded and reported in most centres in line with national policy.

Inspectors found that staff had been provided with safeguarding training and had a good understanding of what constituted abuse and how to report any allegations or suspicions of abuse.

Inspectors also found that there was an improvement in the number and the quality of safeguarding plans in place to help protect residents from risk of harm in many of the centres. However, this was not being consistently implemented across all of the houses. In addition, some safeguarding plans only aimed to address immediate concerns; they were responsive and reactionary to patterns of peer-to-peer altercations but did not effectively address preventive and proactive measures.

The number of residents and compatibility issues with those residents in some houses meant that there continued to be high levels of safeguarding incidents. This resulted in negative experiences for residents. While the provider had plans to further reduce the number of residents in these houses, at the time of inspection, the quality of life for some residents in those houses continued to be negatively impacted.

Inspectors could see improvements in the mind-set and direction of behavioural support in the organisation as evidenced in the monitoring inspections completed in 2018. However, these changes to policy and approach were not yet fully embedded into the day-to-day supports for residents.

Inspectors also found that staff had an improved understanding of the types and management of restrictive interventions. There had been a reduction in the number of restrictive practices being used and this was having a positive impact on residents' rights and their quality of life. While this was an improvement on the findings from

[4] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

previous inspections, there continued to be a high level of restrictive practices in use in the centres. In addition, there was inconsistency in the way restrictive practices were being managed across the centres on the campus.

4.1.3 Outcome 7: Health and safety and risk management

Overall judgment

Inspectors found that there had been an improvement in the recording and collection of data from adverse events on the campus. However, there were gaps in learning from these events as a way to bring about improvements and prevent incidents from reoccurring in some centres. Inspectors found that residents' health and safety was not fully promoted through the provider's risk management systems and further improvements were required.

In general, staff training in fire safety, fire drills and fire safety practices in the centres had improved. However, deficiencies in practice were still identified in some houses, including locked fire exits and break-glass unit keys stored inappropriately outside of the units. In addition, while there were individual evacuation plans for residents, some plans did not clearly identify the support the resident would need to evacuate.

Infection control practices for the most part had improved since the 2017 inspections, and consistent management practices were now emerging. For example, incidents of mould which had been an issue on previous inspections were now quickly identified and addressed to reduce any risks associated with this.

Health and safety and risk management — summary of the 2017 inspections[5]

During the 2017 inspections, inspectors found that the provider was not adequately monitoring, identifying or managing risks to the health and safety of residents, staff and visitors. Issues that were identified through these inspections included fire safety issues, such as an absence of emergency lighting, fire doors not closing properly or being wedged open by staff.

In some of the houses, staff had not participated in a fire drill, and could not demonstrate that they would be able to safely evacuate all residents in a timely manner. Some staff were unfamiliar with the evacuation plans that identified residents' individual supports. Implementing these plans would also not be possible based on the staffing levels in some houses.

[5] Inspection findings from inspections after the issuing of the statutory notice of proposal.

The system for reviewing incidents and adverse events was poor, as was evidence of effective response and learning from them.

Infection prevention and control issues were identified in a number of centres, including a lack of hand-washing facilities, an inadequate response to issues such as mould and poor storage of items that could pose an infection control risk.

Overall, systems in place for managing risk were found to be inadequate, with poor identification of risks and a lack of known and consistent control measures in place to reduce the risk to residents. While the provider took action in response to specific issues found on inspection in 2017, inspectors found similar issues arising in other houses on later inspections.

Health and safety and risk management — summary of the 2018 inspections[6]

During the monitoring inspections in 2018, inspectors found that residents' health and safety was not fully promoted through the provider's risk management systems. While some improvements had been found, these were insufficient and further work was required. In addition, there were inconsistencies in the way in which the improvements were being implemented across the campus.

Inspectors found some improvements to incident management. Nonetheless, the number and frequency of incidents, particularly incidents involving peer-to-peer altercations across the centres remained high. While the provider had implemented an improved system for recording these accidents, incidents and adverse events, the process of reviewing adverse events still needed to improve. There was inadequate learning to help prevent incidents from recurring and inconsistency in the way incidents were being reported and escalated to senior management for review.

In relation to fire precautions, inspectors found improvements in fire drills, evacuation plans for residents and fire safety equipment in many of the houses across the eight designated centres. However, these measures were implemented inconsistently and in some houses:

- fire exits were found to be locked
- evacuation plans did not clearly outline the support that residents required during evacuation and
- fire doors were found to be wedged open.

[6] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

The provider was required to take action to address these issues before the end of the inspection.

Overall, inspectors found improvements in infection control practices on the campus, with an improved response to issues such as mould, provision of hand-washing facilities and hand-washing practices.

4.1.4 Outcome 11: Healthcare needs

Overall judgment

During the 2017 and 2018 inspections, inspectors had significant concerns about healthcare supports to residents. This particularly related to the nutrition and hydration needs of residents, implementation of recommendations from healthcare specialists, and follow up of referrals to allied health professionals. On two occasions it was necessary for inspectors to request assurances during inspection that certain issues relating to healthcare would be swiftly addressed.

On those inspections, mealtimes tended to be generally unpleasant, with institutional arrangements seen, such as hurried and fixed mealtimes to facilitate staff breaks. Inspectors saw that there was often insufficient staff to support residents during meals, and mealtimes were noisy, with staff seen to be multi-tasking while supporting residents with their meal. In some cases, residents were observed to be waiting for breakfast for long periods as staff were busy attending to other residents' needs.

The inspections in 2018 did find some improvement in this area, with meals seen to be much more social and relaxed events.

During the 2018 inspections, inspectors found that the provider had somewhat improved healthcare support to residents; however, improvement had not been implemented consistently across all centres.

Healthcare needs — summary of 2017 inspections[7]

Overall, in 2017, inspectors found that the provider and staff were failing to meet the healthcare needs of residents. Many residents had complex healthcare needs and were not being regularly assessed.

There was a significant number of healthcare needs that did not have corresponding healthcare plans in place to support staff in delivering effective and consistent care to residents. Where there were healthcare plans, staff were unable to demonstrate

[7] Inspection findings from inspections after the issuing of the statutory notice of proposal.

to inspectors their knowledge of those plans. In many instances, inspectors found that the plans were not being implemented.

There was insufficient guidance available to effectively guide staff practice, including in critical areas such as the administration of emergency rescue medications. Inspectors found that staff did not respond appropriately in some cases when residents needed healthcare assistance. Insufficient staffing levels and lack of knowledge contributed to the poor response to residents' healthcare needs.

Some residents who had been referred to specialist services had subsequently not been supported to attend their appointments. Where inspectors found that residents had attended healthcare appointments, the direction of the healthcare specialists was not being consistently implemented.

The management of residents' nutritional needs was found to be poor in some houses on the campus. Inspectors found that there was inadequate monitoring and management of the nutrition and hydration needs of these residents. In some houses, records did not demonstrate that residents were offered snacks or drinks.

Inspectors found that mealtimes were task-oriented and were arranged around staff breaks. While some improvements were observed in some houses over the course of these inspections, it was generally found that there was minimal choice of meal offered to residents at mealtimes.

Healthcare needs — summary of 2018 inspections[8]

The findings of the four monitoring inspections undertaken in 2018 indicated that measurable improvements were made in the identification and assessment of residents' healthcare needs. Residents had access to general practitioner (GP) services, and an annual medical review had been undertaken for each resident. Staff demonstrated improved knowledge of residents' healthcare needs.

However, improvements continued to be required in relation to the review and implementation of healthcare plans. In some cases, it was found that healthcare plans did not provide adequate information to effectively guide staff practice, with generic healthcare information contained in some plans. Furthermore, not all identified healthcare needs had an associated support plan in place.

While efforts had been made to improve oversight of the nutrition and hydration needs of residents, inspectors had concerns about the effectiveness of these measures. Records in some centres indicated that residents were not consistently receiving enough fluid and dietary intake, with long periods between meals and no

[8] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

fluids or snacks available to residents in between. In some cases, immediate assurances were required from the provider about residents' nutrition and hydration.

4.1.5 Outcome 1: Residents' rights, dignity and consultation

Overall judgment

The 2017 inspections found significant non-compliances which impacted on the dignity, privacy and rights of residents. Many residents lived in overcrowded houses and were required to share bedrooms. Restrictive practices were not being monitored or managed in a way that ensured the rights of residents were protected. The routine of the day was determined by staff rosters and breaks rather than in response to the assessed needs of residents.

The findings of four sampling inspections undertaken in 2018 found that improvements had been made to protecting and maintaining the rights and dignity of residents. Improvements had been made to the premises that provided residents with their own private bedrooms, and ensured that residents had their own personal space and that arrangements for care could be carried out in a dignified manner.

Residents' rights, dignity and consultation — summary of 2017 inspections[9]

The actions taken by the provider had resulted in some improvements for a small number of residents in how their privacy and dignity was upheld. The provider had completed works in a number of dormitory-style units, and converted one unit into three individual apartments.

However, inspectors found that residents continued to share bedrooms, while arrangements to protect the privacy and dignity of residents were not effective or appropriately implemented. For example, inspectors found that privacy screens were not being used when intimate care was being provided to residents.

Some other practices in the centre did not protect the privacy of residents. Inspectors found that personal information about residents was available in communal areas, and staff were observed discussing residents' information in front of other residents. Inspectors found an overall lack of awareness of the importance of residents' privacy, and residents were not supported to maintain dignity in their home.

Inspectors found that residents were not being supported to exercise their rights. In some cases, concerns were raised regarding the quality of care, and these concerns were not recorded as complaints or followed up. There were restrictive practices in

[9] Inspection findings from inspections after the issuing of the statutory notice of proposal.

place, including environmental restraints, which had not been assessed to ensure they were appropriate for meeting residents' needs. In some cases, restrictive practices were implemented as a response to reduced staffing levels. The provider had not ensured that residents had access to an independent advocacy service.

While there was evidence that residents were consulted about their care in some houses (for example, one house had regular residents' meetings), there was a continued institutional approach to care. Care arrangements were determined by staffing levels and staff breaks, and daily care and supports, such as showers, were scheduled based on the collective management of residents, and not on the individual needs of residents.

Residents' rights, dignity and consultation — summary of 2018 inspections[10]

The four monitoring inspections undertaken in 2018 showed that the provider had made measurable improvement in the area of residents' rights, dignity and consultation. However, improvements were still needed in some areas.

The provider had carried out significant upgrade works to some of the premises that ensured residents now all had their own bedroom. Other works to the premises had improved residents' privacy and dignity, such as accessible en-suite bathrooms and toilet facilities with improved privacy.

The provider had arranged for a review of restrictive practices within the centres, which resulted in some practices being discontinued and others being reduced. An independent advocate had been made available to residents in relation to upholding their rights in this particular area.

Inspectors found that residents were increasingly being consulted with in relation to their care and support. For example, it was observed that residents' input was sought in relation to planning activities. However, the arrangements in some houses for the preparation of meals did not facilitate adequate choice for residents. Meals came from a central kitchen which offered limited choice, and some houses did not prepare meals or have access to adequate snacks after 5pm.

Arrangements in relation to residents' finances did not facilitate residents to retain control of their own money, and institutional arrangements limited residents' access to their finances. Improvements were found in the management of complaints, and most were responded to promptly.

[10] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

4.1.6 Outcome 17: Workforce

Overall judgment

During the initial inspections in 2017, inspectors found that the provider had made no improvements to the staffing arrangements in the centres. Overall, the number and skill-mix of staff was not appropriate to the assessed needs of residents, which negatively impacted on the lived experience of residents. There was limited choice and autonomy, and the safety of residents' care was compromised. Staff were not being provided with adequate training and supervision, and were unable to demonstrate a sufficient knowledge of the care and support needs of residents. There was a significant number of agency staff working in the centre, which impacted adversely on the service's ability to consistently care for residents.

The monitoring inspections in 2018 found improvements in permanent staffing levels within the centre, with some residents receiving one-to-one support for behaviour support or safeguarding needs. However, a number of residents continued to require additional staff support, particularly to access the community or engage in activities outside of their home. The provider was reliant on the use of temporary agency staff to facilitate residents' access to the community.

The provider had improved the system for staff to access mandatory training and training levels had increased. Nonetheless, there were some deficiencies in this area identified throughout the inspections. The arrangements for supervision, as well as the frequency of team meetings, were observed to have improved throughout 2018. While these changes were found to be inconsistent across centres, they had started to impact positively on staff knowledge and development.

Workforce — summary of 2017 inspections[11]

Inspectors found that staffing levels were insufficient to meet the assessed needs of residents. In many centres, staffing levels were regularly below what the provider had deemed to be adequate (through needs assessment and workforce planning) to provide a safe service to residents. Reduced staffing had resulted in residents being exposed to risk due to lack of appropriate supervision. It was also found in some cases that restrictive practices were used in place of adequate staff supervision of residents.

Inspectors were concerned that staff did not have sufficient knowledge or training to provide care and support to residents in line with their assessed needs. It was regularly identified that staff working in centres did not have knowledge of residents' healthcare or social care needs, and in one case, a staff member did not know

[11] Inspection findings from inspections after the issuing of the statutory notice of proposal.

residents' names. Contingency measures were not effective in ensuring that staffing levels were appropriate and this resulted in an over-reliance on temporary agency staff. Frequent use of unfamiliar staff had impacted negatively on the continuity of care for residents.

Records revealed training deficits in all centres inspected, for example, in one centre just 35% of staff had received training in safeguarding. Staff supervision arrangements were found to be unsatisfactory; there were significant periods of time where a manager was not present in centres. For instance, the local manager was off duty for eight out of 14 days in one centre due to roster arrangements. Formal supervision arrangements were not in place in most centres.

Workforce — summary of 2018 inspections[12]

The four monitoring inspections carried out in 2018 found that a number of areas had improved, such as levels of staffing, mandatory training and staff supervision. However, further improvement was required in each of these areas in order to achieve compliance with regulations.

Inspectors found that there were increased staffing levels, much of which were in response to a requirement to support residents who presented with behaviour of concern or safeguarding needs. While management had a better awareness of staff vacancies within the centres, there continued to be an over-reliance on temporary agency staff to cover shifts.

Further attention was required to ensure that appropriate staffing levels were maintained during the day to provide sufficient care and support to all residents. Staffing levels were found to decrease significantly at night-time, and were inadequate to meet residents' needs.

Staffing arrangements continued to limit choice and participation for residents, with routines driven by the needs of the service and its staff rather than residents' wishes. For example, fixed mealtimes facilitated staff breaks rather than being centred on the needs and wishes of residents.

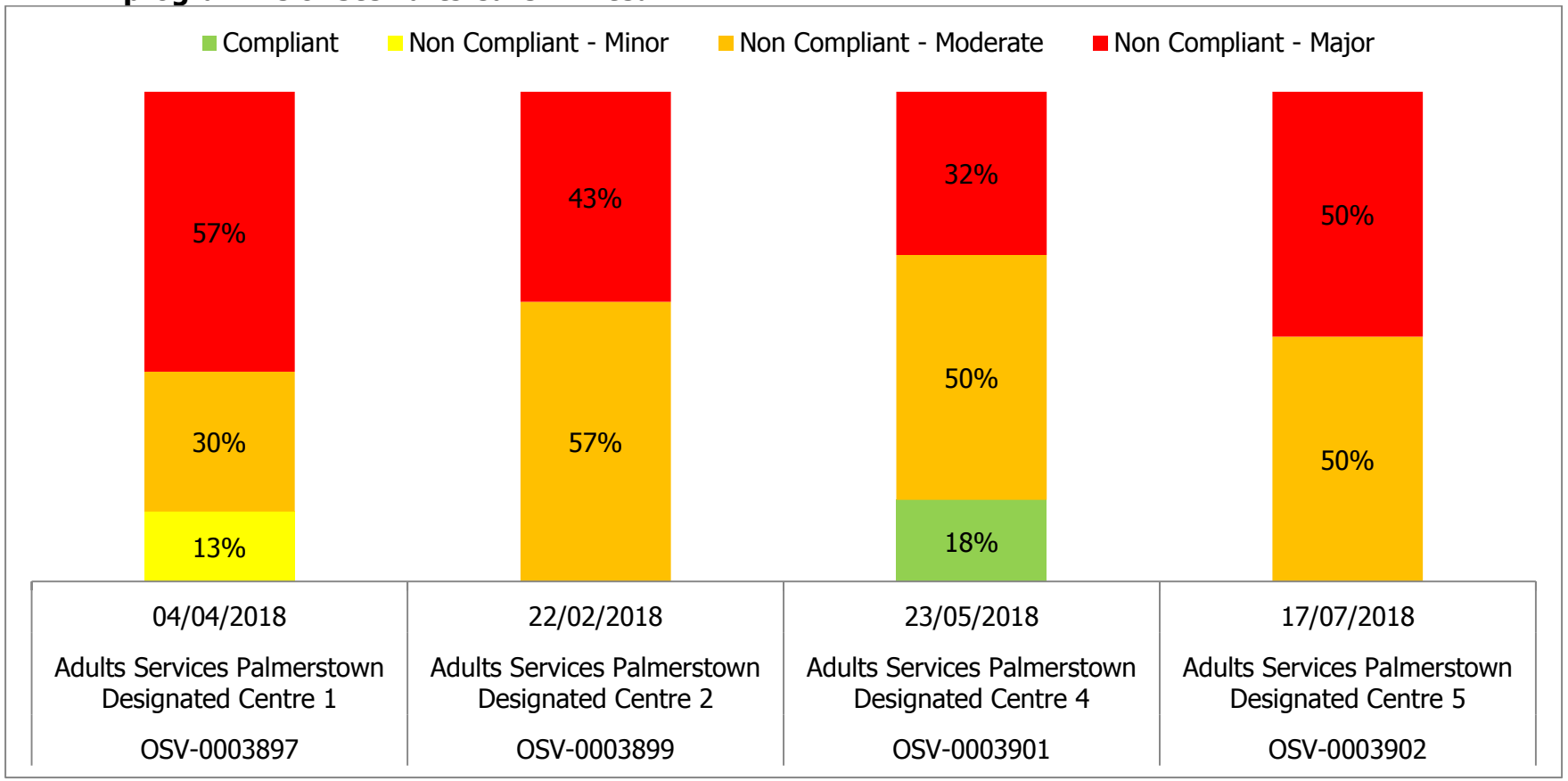
Arrangements to provide mandatory training to all staff had begun to take effect in 2018, with increasing numbers of staff receiving training in areas such as fire safety and positive behavioural support. Sustained effort was required in this area to ensure that all staff had received appropriate training, and the provider demonstrated a plan to address training deficits.

[12] Inspection findings from the four 2018 monitoring inspection findings completed during the regulatory programme.

Staff supervision arrangements had commenced, and inspectors observed records of regular supervision meetings being maintained in some centres, although this was not consistent in all houses. The frequency of team meetings had also improved, although similarly, this had not been consistently implemented in all areas.

Mechanisms implemented to ensure that the requirements of Schedule 2 of the 2013 care and support regulations were in place were found to be effective. Staff files reviewed by inspectors contained all of the required information, such as proof of identity and references.

Chart 2. Levels of non-compliance of four monitoring inspections carried during the six-month regulatory programme of Stewarts Care Limited



4.2 Inspector visits to meet with residents – September 2018

In September 2018 inspectors visited each of the eight designated centres to spend time with residents and to observe whether the changes implemented by the provider were having an impact on the quality of life for residents.

These visits indicated that the care provided was, for the most part, becoming more person centred and staff had an improved knowledge regarding residents' needs and preferences. Inspectors saw that the actions of the provider had resulted in improvements in the quality of life for residents in many of the houses. However, these improvements were not consistent across all of the houses.

Inspectors found that there had been a significant improvement in enabling residents to engage in social activities of their preference in many of the houses. Residents also told the inspectors of recent holiday breaks away from the campus and their plans to go on future holidays. Inspectors were informed of and observed residents having a range of activities or work-based options to avail of, such as working in local restaurants and shops or attending day services where they engaged in hobbies and activities of interest.

Residents who spoke with inspectors described who they would speak with if they were unhappy or worried about something. In many of the houses, inspectors saw that there was a more person-centred approach to engaging with residents and residents were involved in deciding on the routines of the house. Inspectors noted that residents were facilitated to attend regular residents' meetings and they were supported to make choices in relation to their daily lives such as food menus and social activities. However, this was not implemented consistently in all houses and inspectors saw that staff in some houses took a more task-oriented approach to supporting residents.

Overall, the observations from these visits provided inspectors with assurances that the new governance arrangements were becoming more effective at providing a service that was meeting the needs of residents. Albeit, this was not consistent throughout all of the centres and further progress and improvement was required to ensure all residents were provided with high-quality and safe services.

5. Conclusion

During 2017, inspectors found that there was a significantly poor standard of care and support provided to residents across most of Stewarts Care Limited centres. In these centres, the rights of residents were not being promoted and the social and healthcare needs of residents were not being supported appropriately.

Following regulatory intervention and a requirement by the chief inspector for the provider to plan and make improvements, the provider began to improve its oversight and governance of the centres, and improve the standard of care and support to residents.

In the initial stages of this escalated regulatory programme, inspectors found that while the provider was taking actions to improve overall management arrangements in the services, there was insufficient progress being made in achieving improvements in the safety and quality of life for residents.

When inspectors visited the centres in September 2018 to spend time with residents, they found that improvements were being made for residents. However, further work is required to ensure that the provider sustains the progress made and continues to improve the standard of care and support that all residents in its care are entitled to.

Between 2017 and January 2019, eight residents have successfully moved from their campus setting into a more appropriate placement in the community as part Stewarts Care Limited's transition process. As of January 2019, there were 152 residents still living in the provider's campus-based settings.

Moving forward

Following this escalated regulatory programme, the provider was informed that while there continued to be relatively high levels of non-compliance with the regulations and National Standards in the centres, there was evidence that residents' quality of life was improving. However, the provider was advised that this progress must be sustained and that further improvements are needed.

The provider was informed that applications to register newly reconfigured centres on its Dublin campus would be accepted, but before a final decision on registration was made, inspectors would require an individual improvement plan for each centre.

Since December 2018, inspectors have been carrying out a schedule of inspection activity in order to inform a registration decision on these applications. Reports on these inspections will be published in the coming months.

Overall, inspectors have found that while there are still a number of houses that need increased oversight by the provider and improvements in the quality of care being delivered to residents, the provider is implementing their improvement plans and inspectors are seeing improvements to the quality and safety of care for residents living in these centres.

At the time of publishing this overview report, consideration is being given to the provider's applications to register the increased number of designated centres on the campus and in the community, as part of the provider's reconfiguration and improved management arrangements.

Inspectors will continue to closely monitor these centres to ensure that the improvements achieved by the management and staff working in the centres and by the provider are sustained and continue to deliver improved services to the residents and that these improvements promote and protect the rights of residents living in these centres.

Appendix 1 — Engagement with Stewarts Care Limited from May 2017 to November 2018

Date	Type of engagement between inspectors and the registered provider	Brief description
18 May 2017	Unannounced inspection	Inspection to monitor regulatory compliance of designated centre 4.
1 June 2017	Unannounced inspection	Inspection to monitor regulatory compliance of designated centre 6.
19 June 2017	Notification of announced inspection	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relatives to fill in were sent to designated centre 1.
26 June 2017	Notification of announced inspection	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relatives to fill in were sent to designated centre 2.
28 June 2017	Provider meeting	Meeting to issue statutory notice of proposal to cancel registration of Adult Services Palmerstown designated centre 4 and designated centre 6.
3 July 2017	Announced inspection	Inspection to inform a registration renewal decision for designated centre 1.
13 July 2017	Announced inspection	Inspection to inform a registration renewal decision for designated centre 2.
19 July 2017	Unannounced inspection	Inspection to inform a registration renewal decision for designated centre 5.
27 July 2017	Unannounced inspection	Inspection to inform a registration renewal decision for designated centre 3.
9 August 2017	Provider meeting	Meeting to issue statutory notice of proposal to cancel registration of Adult Services Palmerstown Designated centres 1, 2, 3 and 5.
19 September 2017	Notification of announced inspection	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relatives to fill in were sent to designated centre 8.
22 September 2017	Representation panel	Review of submissions received from the provider.
25 September 2017	Notification of announced inspection	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relatives to fill in were sent to designated centre 7.
29 September 2017	Email to Chief Executive Officer of Stewarts Care Limited	Email from inspectors to Chief Executive Officer of Stewarts Care Limited informing it of the outcome of the representation panel and the subsequent actions.
5 October 2017	Announced inspection	Inspection to inform a registration renewal decision for designated centre 8.
09 October 2017	Announced inspection	Inspection to inform a registration renewal decision for designated centre 7.
19 October 2017	Unannounced inspection	Inspection to inform a registration renewal decision for designated centres 1.

Date	Type of engagement between inspectors and the registered provider	Brief description
19 October 2017	Unannounced inspection	Inspection to inform a registration renewal decision for designated centres 5.
23 November 2017	Notification of announced inspection	The registered provider is informed of the announced registration inspection in advance. Posters and questionnaires for residents and relatives to fill in were sent to designated centre 4.
7 December 2017	Unannounced inspection	Inspection to inform a registration renewal decision for designated centre 3.
8 December 2017	Phone call to Chief Executive Officer of Stewarts Care Limited	From inspector to the Chief Executive Officer of Stewarts Care Limited to outline serious concerns and the lack of progress on improving safety and the quality of life for residents.
11 December 2017	Announced inspection	Inspection to inform a registration renewal decision for designated centre 4.
15 December 2017	Email to Chief Executive Officer of Stewarts Care Limited	From inspector requesting detailed plan for each of the six campus-based designated centres and two community-based centres.
21 December 2017	Provider meeting including a representative of the Health Service Executive (HSE).	Meeting to give members of the senior management team at Stewarts Care Limited an opportunity to ask further questions regarding the six-month regulatory programme. Representative of the HSE were invited by the Chief Executive Officer of Stewarts Care Limited.
8 January 2018	Provider meeting	Meeting for the provider to present the centre-specific plans which will focus on bringing the eight centres (DC1-DC8) into compliance.
12 January 2018	Letter to Chief Executive Officer of Stewarts Care Limited.	Letter from inspector detailing concerns and requesting a revised plan following the meeting of 8 January 2018
29 January 2018	Email to Director of Care of Stewarts Care Limited.	From inspector which confirmed the tracker the Director of Care would be using to support the completion of assurance reporting.
7 February 2018	Assurance reporting	Provider meeting to discuss and outline monthly monitoring report for January 2018.
22 February 2018	Unannounced inspection	Inspection to inform a registration renewal decision for designated centre 2.
13 March 2018	Assurance reporting	Provider meeting to discuss and outline monthly monitoring report for February 2018.
26 March 2018	Letter to Chairman of the Board of Stewarts Care Limited.	Letter from inspector outlining response to letter from Chairman of Stewarts Care Limited of 12 March 2018.
4 April 2018	Short announced inspection	Inspection to inform a registration renewal decision designated centre 1, announced the day prior to the inspection.
5 April 2018	Letter to Chairman of the Board of Stewarts Care Limited.	Letter from inspector detailing specific concerns and requesting detailed governance plan be submitted by 13 April 2018.

Date	Type of engagement between inspectors and the registered provider	Brief description
5 April 2018	Letter to Chief Officer HSE Area 7.	Letter from inspector detailing specific concerns following inspections.
11 April 2018	Provider meeting	Meeting to discuss concerns regarding inspection of designated centre 1 on 4 April 2018.
8 May 2018	Assurance reporting	Provider meeting to discuss and outline monthly monitoring report for March and April 2018.
23 May 2018	Unannounced inspection	Two-day inspection to inform a registration renewal decision for designated centre 4.
12 June 2018	Assurance reporting	Provider meeting to discuss and outline monthly monitoring report for May 2018.
11 July 2018	Letter to Chief Executive Officer of Stewarts Care Limited.	Letter from inspector regarding the transfer of a resident into designated centre 4 (following transfer of this resident into designated centre 10, which led to breach of conditions in designated centre 10).
17 July 2018	Unannounced inspection	Inspection to inform a registration renewal decision for designated centre 5.
22 August 2018	Provider meeting	Meeting to present overview of findings of 2018 monitoring inspections and inform provider of upcoming programme of unannounced visits.
5 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 1.
5 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 3.
5 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 5.
5 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 8.
13 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 2.
13 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 4.
13 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 6.
13 September 2018	Unannounced visit	Visit by inspectors to spend time with residents and observe their quality of life Centre 7.
13 September 2018	Provider meeting	Meeting with the provider on conclusion of the September visits on the Stewarts Care Limited campus.
14 November 2018	Receipt of registration applications	Provider submitted 27 revised registration applications to the Office of the Chief Inspector.

Published by the Health Information and Quality Authority.

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