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 6
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	17 June 2021
Centre ID:	OSV-0005831
Fieldwork ID:	MON-0028431

About the designated centre

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

Designated Centre 6 is comprised of four houses located in housing estates across West Dublin. It provides full time residential care in a community setting, and can accommodate up to 12 adults, with intellectual disabilities. The centre is staffed by care assistants and day service team members, all of who are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Thursday 17 June 2021	09:20hrs to 17:20hrs	Ciara McShane	Lead
Thursday 17 June 2021	09:20hrs to 17:20hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

In line with public health guidance, the inspectors did not spend extended periods of time with residents and only visited one of the four houses which make up the designated centre. The inspectors met with residents and staff in this house at the beginning of the inspection before completing a brief walk through of the premises. Documents and records were reviewed in the service provider's head office. Two residents also completed questionnaires which were made available to inspectors. The inspectors used observations and discussions with residents in addition to a review of documentation and conversations with key staff to form judgements on the residents' quality of life.

Residents were observed freely accessing areas of their home before some of them left to go on an outing with staff. Residents generally spoke positively about their experiences of living in their home. They described good relationships with staff and outlined the activities which they participated in both at home and in their communities. The resident questionnaires detailed that residents were happy with their bedroom facilities, the food in the designated centre, their activities, the staff and the choices available to them. One area which was raised by residents as an area requiring improvement was the arrangements in place for receiving visitors. Visitors to the designated centre must visit residents in their bedrooms, wear personal protective equipment (PPE) and adhere to other COVID-19 measures including signing in and out and practicing good hand hygiene.

The inspectors saw that the physical environment of the house was clean however it was in need of redecoration and general maintenance and repairs. Maintenance requests had been logged with the service provider however there was evidence that many of these were outstanding or had not been resolved satisfactorily. For example, minutes of a staff meeting noted that two residents had issues with reoccurring mould in their bedrooms which had been managed by painting over the mould. Further premises issues are outlined under the Quality and Safety section.

The front and rear garden was maintained by the residents and staff at the centre. At the time of inspection there was seating outside for four persons along with a garden table. A number of the external windowsills required repainting as they were heavily chipped as a result of the paint peeling away. There was a swing ball game also in the garden for residents to avail off.

At the time of inspection the inspectors observed, and were informed, that a second sitting room was being developed for residents to relax in. This was due to the behaviours of another resident which in the past had resulted in residents sometimes having to go to their room. While this room was not complete and a significant amount of decor and work was required to make it homely the person in charge told the inspector it was underway.

Staff were observed interacting positively and respectfully with residents, offering

residents choices regarding their day. Day service staff had been transferred to residential services due to the COVID-19 pandemic and the person in charge reported that this had resulted in an increased opportunity for residents to engage in individualised day services within their community.

The next two section of the report refers to the capacity and capability of the provider and the quality and safety of the service provided. Whilst the provider ws endeavoring to meet the needs of the residents the governance and management arrangements of the centre in addition to the staffing arrangements and the management of residents' needs required a review.

Capacity and capability

It was found on inspection that while the intentions of the provider were positive and the staff whom the inspectors met were warm and engaging, overall the governance and management arrangements did not ensure the service provided was sufficiently monitored and met the needs of all residents.

The inspectors met with the person in charge who had commenced her role in this centre in September 2020. The person in charge had oversight of four units which made up this designated centre. Her role was full time and she met the requirements of the regulations. Although her role was full time, half of her hours were rostered for her to work on the floor, with the remaining fifty percent assigned to her responsibilities as a person in charge. The inspectors found that due to the large number of units under her remit, in addition to the complex and changing needs of residents and the level of non-compliance found on this inspection, she was stretched in her role and did not have the capacity to fulfill her regulatory remit.

The person in charge was supported by a programme manager and documentation demonstrated that they attended meetings together on a regular basis. However, the inspectors found that due to the large remit of the person in charge and due to the recent nature of her position, more support was required to ensure there was sufficient monitoring and oversight of the centre.

The inspectors found although there were some monitoring systems in place such as the annual review, they were not effective in identifying key areas of concerns such as deficits in healthcare plans and assessment of needs. The oversight of staffs' training was also poor and required further attention as did the oversight of risk management in terms of incidents and accidents and the overall management of risk in relation to applying the appropriate risk ratings and controls specific to the identified risk.

An annual review and the relevant six monthly unannounced visits had been completed. However the action plan which formed part of the annual review was not measurable and it did not identify who the responsible person was for each action. This required a review. The provider had recently developed an audit schedule that

the person in charge was imminently going to introduce as a tool to monitor the service provided.

The centre was staffed by healthcare assistants in addition to day activation staff who were seconded from day services as a result of their closure due to COVID-19. At the time of the previous inspection and up until September 2020 there was nursing staff available to support staff with residents' needs but at the time of this inspection there was no nursing staff working at the centre nor was there a vacancy identified to employ same. The person in charge confirmed there was no nursing support and had communicated the need for same to her line manager at meetings. The inspectors found, from a review of residents' needs and the significant number of deficits in residents' healthcare plans in particular, that the current skill mix was inadequate and nursing staff was required to support the staff, develop care plans and provide additional clinical governance. The person in charge was endeavouring to ensure residents' care plans were up-to-date and appropriate, however her capacity to complete this task was stretched and as a result there was a risk that healthcare needs were not being met as a result of unclear or absent care plans. This is further outlined in the Quality and Safety section.

The inspectors reviewed staff training records and found that the oversight of training and the identification of what staff required and when was poorly managed. From the records reviewed the inspectors were able to determine that several staff had not completed or had out of date certification in key training areas including fire safety, managing behaviour that is challenging, safeguarding and Children First. Access to training was reported to be limited due to public health restrictions. Training records were not maintained in a way that provided a concise and clear overview of the staff training needs. In some cases there was evidence that training had taken place locally but had not been recorded by the service provider's learning and development team on individual staff member's records. Supervision records were available for staff, demonstrating that they had received regular supervision from the person in charge. First aid training had been secured for some staff for later in the month.

There was a planned and actual rota in place which was maintained and reflected changes in the rota such as sick leave or annual leave. The inspector briefly engaged with staff during the inspection and observed their practice. Staff were observed supporting residents in a kind and compassionate manner during the inspection.

Regulation 14: Persons in charge

The centre was managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured the skill mix of was appropriate to the residents' assessed needs.

The person in charge was working half her hours on the floor which was impacting negatively on her ability to have full oversight of the designated centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Several staff had not completed or had out of date certification in key training areas including fire safety, managing behaviour that is challenging, safeguarding and Children First. First aid training had been secured for some staff for later in the month.

Access to training was reported to be limited due to public health restrictions. Training records were not maintained in a way that provided a concise and clear overview of the staff training needs.

In some cases there was evidence that training had taken place locally but had not been recorded by the service provider's learning and development team on individual staff member's records. Supervision records were available for staff, demonstrating that they had received regular supervision from the person in charge.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements did not ensure that management systems were in place to ensure the service provided was safe, appropriate to residents' needs and effectively monitored. There was a lack of systems to review and monitor all elements of the designated centre including risk, care planning, meeting residents' assessed needs and training.

Although there was an annual review completed the action plan was not SMART therefore it was unclear as to who was responsible for each action and when it had

to be completed by.

The person in charge had highlighted the nursing skill deficit to the provider as a concern however the issue was not addressed or known to all key stakeholders at provider level. As a result the inspectors were not assured the mechanisms used by the provider to facilitate staff to raise concerns was effective.

The person in charge was stretched in terms of her allocated time to ensure complete oversight of the centre. The provider had not ensured her working arrangements at the time of inspection supported her capacity to fulfill the requirements of the regulations under her remit.

Judgment: Not compliant

Regulation 34: Complaints procedure

An up to date complaints policy was available however it was found that there was an inadequate system to log and respond to all complaints. The person in charge reported two complaints in the last twelve months which had been resolved locally however there was evidence of other complaints on staff meeting minutes which were not detailed in the complaints log.

Judgment: Substantially compliant

Quality and safety

Overall, it was not demonstrated the provider had the capacity and capability to ensure the consistent provision of a good quality and safe service to residents. Improvements were required in key areas such as healthcare, risk and assessment of needs. There was a risk that if the shortcomings were not reviewed and actioned in a timely manner it would have a negative impact on residents' well being.

The inspectors reviewed a sample of residents' assessment of needs and supporting care plans. From the selection reviewed it was demonstrated that each of the residents had an annual medical review with their General Practitioner (GP) that included screening in line with the National Screening Programme where required. The inspectors saw evidence of input from multi-disciplinary teams and allied health professionals.

While each resident had an assessment of need in place and some associated care plans, it was found that a significant number of those reviewed by the inspectors had not all been reviewed at a minimum annually in line with the requirements of the regulation. It was evident that referrals, for the most part, had been made in a

timely way by the person in charge, but these had not always been responded to. For example, input from a dietitian was required for a resident however at the time of inspection this was still outstanding. A referral had also been submitted, December 2020, for a resident as their Feeding, Eating and Drinking plan (FEDs) had not been reviewed since January 2020 but this remained outstanding.

From a review of one resident's needs it was noted that they required support and input with numerous aspects of health, the inspectors found there was an absence of an overarching plan guiding staff on how they could support this resident from a nutritional and dietetic perspective.

Another resident's supports regarding their feeding, eating and drinking was reviewed. The inspectors reviewed the care plan, in addition to notes from appointments and a supporting risk assessment. The information in relation to the resident's support needs varied, with one document stating they required a mince moist diet and another stating a liquidised diet and a risk assessment also referred to the use of a blender. There was also an absence of a robust up-to-date care plan, developed by a competent person, this therefore created a risk that the resident was not being supported correctly and consistently with their FEDs requirements.

Furthermore it was found that staff required training in dysphagia and the management of choking. Overall the inspector was not assured that residents' needs in relation to key areas such as FEDs, dietetic needs and other complex needs were being reviewed at regular intervals, consistently met or that staff were clear on how they should be met as the care plans and associated documentation such as risk assessments were unclear and ambiguous in places. This required a review, for all residents, to ensure their needs were being supported. The provider stated at the time of inspection they would prioritise a clinical nurse specialist to link in with the designated centre and complete a review. These findings also reinforced the requirement for nursing support in this centre.

The provider had a system in place to ensure residents were safeguarding and free from abuse. This included an up-to-date policy, the provision of training to staff and the use of safeguarding plans. On this inspection a number of safeguarding plans were in place and one in particular had proven to be effective with a reduction incidents. The person in charge, at the time of inspection, was repurposing the use of a dining room to better support the needs of residents in relation to incidents residents may witness. A small number of safeguarding plans were out of date. For example, one had not been reviewed in two years. Deficits were found in relation to staff training. Eleven staff had completed the safeguarding training, five had not completed the training and seven were out of date and required a refresher.

The provider had a risk management system in place and was supported by a risk management policy. A risk register was completed for the centre and there were also individual risk assessments in place for residents.

The inspector reviewed a number of the individual risks and found them to be inconsistent. While for the most part the risk assessments were reviewed in a timely manner, the risk ratings applied did not coincide with the actual risk in terms of the

likelihood and the impact. For example, for one resident the risk of choking was risk rated green but the impact and likelihood as well as the gaps in controls did not reflect such a low risk rating. The risk assessment also failed to outline all potential choking risks for this resident, including their risk of choking on tablets. The same resident was also at risk of falls, and had recently had falls which resulted in injury, however this too was risk rated green.

The risk register was reviewed and the inspectors found that all red rated risks had not been placed on the risk register. In addition risks, such as the risks associated with COVID-19, were generic in nature and not individualised to each resident.

In relation to incidents and accidents that occurred at the centre the person in charge was unable to demonstrate how these were audited, trended and reviewed on a regular basis. It was therefore unclear how learning was gained. Overall the inspectors were not assured there was a clear understanding of risk management and found that the management of risk in the centre required a review.

The inspectors found that there were clear policies and procedures observed and documented on the day of inspection which outlined a positive risk taking approach to the prevention of infection, particularly to the prevention of COVID-19. Temperature checks were taken at the door and there were sign in sheets for visitors to facilitate contact tracing. Adequate hand washing and hand sanitising facilities were observed. An infection control folder with the infection control policy was made available to inspectors. The provider operates a risk committee who complete COVID-19 related risk assessments for visitors to the service and when residents wish to visit their families or community. Staff outlined that as part of this risk assessment the impact of restrictions on the resident is also set out and considered. A fridge temperature recording sheet and daily cleaning schedules were also kept and made available to inspectors.

The designated centre consisted of four units, of which the inspectors observed one. From observations of this centre, whilst it was clean and tidy, a number of repairs, upgrades and general maintenance work was required. At the time of the inspection the staff were in the process of repurposing the use of a dining room into an additional sitting area for residents and this was viewed as a positive step. Although the inspectors did not get to visit the remaining three units, on this inspection, the person in charge relayed areas relating to premises that required a review in these units. In particular the layout of one unit was not meeting the needs of the residents living there. The inspectors were not assured that the system in place to manage maintenance and repairs was adequate, however the provider informed the inspectors that a new system had been introduced which would see all outstanding works being completed in a coordinated manner.

Regulation 17: Premises

The unit which inspectors visited was observed to be clean and tidy. Staff were in the process of converting a dining room to a sitting room on the day of the

inspection. Staff explained that this was to meet the needs of residents who had requested an additional living space. A spacious garden was accessible to residents with a swingball and rackets set. Inspectors did not visit residents' bedrooms however residents who were spoken to on the day reported that their bedrooms were decorated to their tastes and they had chosen their own furniture.

The premises and garden were found to be in need of general maintenance and upgrades. The garden table was observed to be cracked and the paint on the windowsills on the exterior and interior of the kitchen windows was cracked and peeling. A kickboard was missing from underneath a kitchen press. Walls in the downstairs of the premises were noted to be in need of painting and there was some mould and damp spots observed on the ceiling and the wall in the utility room. The bathroom upstairs was in need of refurbishment and repair. There was mould in the bathroom and the flooring needed to replaced, overall the lack of maintenance on the bathroom posed as an infection control risk as not all surfaces could be kept clean due to cracks, moulds or objects such as the flooring lifting. It was also observed that a number of the bedroom doors upstairs had previously been damaged and even though a repair job had been completed the damage was still visible.

Minutes of a staff meeting in February 2021 also detailed long standing issues with mould in two of the residents' bedrooms which had not been adequately treated. A record of maintenance requests for the four units over the last 12 months outlined that staff had requested various maintenance tasks including painting, domestic appliance purchases and repairs, tiling and deep cleaning of carpets however many of these requests were outstanding. On the day of inspection there were 11 out of 16 maintenance requests for one of the units outstanding.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Overall the inspectors were not assured there was a clear understanding of risk management and found that the management of risk in the centre required a review.

The inspector reviewed a number of the individual risk assessments and found them to be inconsistent. While for the most part the risk assessments were reviewed in a timely manner, the risk ratings applied did not coincide with the actual risk in terms of the likelihood and the impact. For example, for one resident the risk of choking was risk rated green but the impact and likelihood as well as the gaps in controls did not reflect such a low risk rating. The risk assessment also failed to outline all potential choking risks for this resident, including their risk of choking on tablets. The same resident was also at risk of falls, and had recently had falls which resulted in injury, however this too was risk rated green.

The risk register was reviewed and the inspectors found that all red rated risks had not been placed on the risk register. In addition risks such as the risks associated with COVID-19 were generic in nature and not individualised to each resident.

In relation to incidents and accidents that occurred at the centre the person in charge was unable to demonstrate how these were audited, trended and reviewed on a regular basis. It was therefore unclear how learning was gained and applied.

Judgment: Not compliant

Regulation 27: Protection against infection

There were clear policies and procedures observed and documented on the day of inspection which outlined a positive risk taking approach to the prevention of infection, particularly to the prevention of COVID-19. Temperature checks were taken at the the door and there were sign in sheets for visitors to facilitate contact tracing. Adequate hand washing and hand sanitising facilities were observed. An infection control folder with the infection control policy was made available to inspectors.

The provider operates a risk committee who complete COVID-19 related risk assessments for visitors to the service and when residents wish to visit their families or community. Staff outlined that as part of this risk assessment the impact of restrictions on the resident is also set out and considered. A fridge temperature recording sheet and daily cleaning schedules were also kept and made available to inspectors.

Judgment: Compliant

Regulation 28: Fire precautions

Adequate clear means of escape with easy access to emergency exit keys were observed in the unit which inspectors visited. There was evidence of good fire safety practices in the designated centre's emergency evacuation folder. For example, up-to-date individual emergency evacuation plans for each resident were available, as well as a record of resident participation in fire drills in the previous 12 months. The dates of fire drills in the last 12 months were logged along with the time it took to evacuate all residents safely. Fire drills were noted to take place under varying staffing levels and at different times of the day. However, it was found by inspectors that while resident individual evacuation plans were up-to-date there were gaps in how these documents were maintained which presented a risk to residents. Some individual evacuation plans did not include detail of the specific supports which residents required to evacuate safely. For example, it was noted on one fire drill

report that a resident who has a hearing impairment uses a vibrating watch and bed-shaker to alert him to the fire drill, however these were not recorded on his individual emergency evacuation plan. Furthermore, an evening time fire drill had identified a risk as this resident had removed his watch and was not in bed at the time of the fire drill and so was not alerted to the need to evacuate until staff came to his room and prompted him to leave.

Gaps were also identified in the provision of fire safety training to staff. Thirteen staff were recorded as having up to date fire safety training while 10 staff required an updated fire safety training.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

While each resident had an individual assessment and personal plan in place, it was found that not all care plans were reviewed in a timely manner.

It was also found that not all care plans reviewed or developed were done so by the appropriate person such as a multidisciplinary professional or an allied health professional. For example, a dysphagia care plan was developed by a care assistant without input from a relevant professional.

Changes to residents' needs for example feeding, eating and drinking, were not clearly outlined nor was the rationale for same outlined.

Where changes were made, for example during an exchange of communication with a speech and language therapist, all relevant care plans were not updated and aligned to the revised plan of care.

Judgment: Not compliant

Regulation 6: Health care

The provider had not ensured that residents were receiving appropriate health care with regard to their personal plans. Referrals had been made and not followed up on with regards to complex needs.

In addition a dietitian was not available to provide support to residents and guide staff to meet the relevant needs.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Behaviour support plans were in place for residents and guided staff effectively on supporting residents such as outlining what their response should be and how they should interact with residents when things are difficult for them.

There were gaps in training to support staff with managing behavioural support needs. seventeen staff were up-to-date whilst six were out of date and two of these have been out of date since 2019.

Judgment: Substantially compliant

Regulation 8: Protection

A small number of safeguarding places were out of date. For example, one had not been reviewed in two years.

Deficits were found in relation to staff training. Eleven staff had completed the safeguarding training, five had not completed the training and seven were out of date and required a refresher.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 6 OSV-0005831

Inspection ID: MON-0028431

Date of inspection: 17/06/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. A Full time nurse will be assigned to DC6, commencing on 01.09.2021. 2. There is Community Liaison Nurse commencing in Stewarts Care in September 2021 to support service users in Community Homes with health care needs. 3. Both nurses will be responsible for supporting the person in charge for ensuring the health care needs of the residents are appropriately assessed, plans are in place to meet these needs and these plans are appropriately evaluated and reviewed. 1. Social Care workers are being recruited to work in DC6.Having this skill mix will enhance the team currently in place and will support the Person in charge in the management of the DC. 4. A Mental Health Intellectual Disability Liaison Nurse commenced in July 2021.This post will support service users in Community Homes with mental health care needs.	
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. A Training Audit will be completed monthly by Person in Charge and a training log has been developed in line with this audit.	

2. The Person in Charge will use this training log to identify gaps in training and staff development requirements.

3. This information will be communicated during supervision and staff meetings and SMART goals will be developed with staff to achieve these training objectives and ensure compliance with training.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Registered Providers Care Management Team (CMT) has initiated a new process of weekly reviews of residents presenting with significant concerns. This is a new measure to proactively support residents in needs of further interventions. The CMT has engaged supports of the Risk and Safeguarding departments to partake in the reviews and put in place supports required.

2. The Person in charge submits a monthly report to the Programme Manager which identify needs and supports. This is discussed at the monthly care management team meeting with the Director of Care.

1. A Full time nurse has being appointed to DC6, commencing on 01.09.2021.

2. Social Care Leaders are being recruited to work in DC6 as a support to Person in Charge ensuring stronger governance and oversight in each house .interviews on 5th August 2021.

3. A Community Liaison Nurse is commencing in Stewarts Care in September 2021 to support non nursing staff service users in Community Homes with service user's health care needs.

4. A Mental Health Intellectual Disability Liaison Nurse commenced in July 2021 to support service users in Community Homes with mental health care needs.

There is Compliance tracker in place for Person in Charge /Programme manager to ensure action plans from audits are being carried out in a timely manner.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure: 1. PIC will discussed and review the complaints policy at staff meetings Person in Charge will develop an active complaints log of all complaints in DC6 including the outcomes. This log will be updated as necessary by the Person in Charge.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Home improvements will commence on the inspected unit on 09.08.21, in which all issues addressed will be resolved; a new kitchen will be fitted, the entire house will be painted, a new bathroom upstairs will be fitted, the mould will be treated and affected areas will be painted. 2. The other units will be refurbished and maintenance issues will be repaired by the newly appointed home improvement team. A schedule of works is currently being developed by technical services. The Person in Charge will complete an audit of the premises to identify domestic appliances that are required and acquire funds for these appliances.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. The Person in Charge met with Risk Management team in July 2021 to review Risk assessments and risk register. A robust plan was developed by the risk management team following this meeting and a timeframe for the implementation of this plan has been developed. The risk management team provided the Person in Charge with a skills development workshop on how to use the risk matrix more effectively and appropriately. For one resident the risk of choking was risk rated green and this rating was revised and adjusted accordingly. The same resident was also at risk of falls, this assessment was also revised and risk rating adjusted. In risk descriptions for both, incident trends in past 6 months have been included and more specific additional controls have been listed for implementation.	

2. The Person in Charge will liaise with relevant clinical nurse specialists, SLT, physiotherapist, and other MDT members to develop more robust risk assessments that suitably inform care staff on how best to reduce risk in the units on a daily basis. These risk assessments will be reviewed as necessary by Person in Charge in liaison with the risk management team.

3. The service level risk assessments will undergo a complete review in line with the risk register by the Person in Charge in liaison with the Risk Management team.

4 The sharing and communication of the revised risk assessments and incident trends and actions to prevent recurrence will be included as a standing agenda item at staff meetings and documented.

5.The risk register has been updated to include the following: the regulation 26 risks (The unexpected absence of any resident / service user, accidental injury to residents / service users / visitors or staff, aggression and violence, and self-harm), Risk of fire, Covid-19, Choking and Slips/ Trips/Falls

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Service user's Personal emergency evacuation plans will be reviewed by the Person in Charge. Within this review, the Person in Charge will include any fire evacuation aids and mechanisms individuals require to safely evacuate the building, for example bed shakers and vibrating watches.

2. Person in Charge will audit fire training use this training log to identify gaps in training and staff development requirements. This information will be communicated during supervision and SMART goals will be developed with staff to achieve these training objectives.

The staff that require fire safety training have completed same.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual

assessment and personal plan:
1. A Full time nurse will commence in the DC in September 2021. A robust review of all health care plans will be carried out and all relevant health care plans will be developed and updated.

2. MDT, community liaison nurse and appropriate allied health Professionals will be involved in the development, implementation and review of health care plans as appropriate.

Care staff will be provided with support and information on implementing health care plan actions, through learning and development, relevant allied health Professionals and community liaison nurse.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. A Full time nurse assigned to DC6 is commencing on 01.09.2021.

2. A Community Liaison Nurse will be commencing in Stewarts Care in September 2021 to support service users in Community Homes with health care needs.

3. Both of these nurses will be responsible for supporting the Person in Charge for ensuring the health care needs of the residents are appropriately assessed, plans are in place to meet these needs and these plans are appropriately evaluated and reviewed with relevant allied health Professionals and MDT.

4. A Mental Health Intellectual Disability Liaison Nurse commenced in July 2021 .They will support service users in Community Homes with mental health care needs.

5. The FEDS plans have been reviewed and updated since the inspection.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person in Charge has completed a training audit and identified the staff that

require training with managing behavioural support.

2. The Person in Charge will advise relevant staff members through supervision and identify what dates training will be completed within as short a time frame as possible.

3. The CNS in positive behavior support is currently developing specialized training for behavior support.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge met with Safeguarding team to review all safeguarding plans and identify necessary update requirements.

2. The Person in Charge will advise relevant staff members through supervision and identify what dates training will be completed within as short a time frame as possible.

The Person in Charge has identified that 8 staff out of the 12 that had not identified they had completed safeguarding training, had completed it but had not sent their certificates to learning and development to be uploaded to the organization's register of training. The training audit will eliminate further instances of this as the Person in Charge will be aware of all training that has been undertaken.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/09/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/09/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	30/08/2021

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/12/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	01/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/09/2021
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to	Not Compliant	Orange	27/07/2021

	residents.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	27/07/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	27/07/2021
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	27/07/2021
Regulation 34(2)(f)	The registered provider shall ensure that the	Substantially Compliant	Yellow	27/07/2021

	nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	30/11/2021
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/11/2021
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and	Not Compliant	Orange	30/11/2021

	shall include any proposed changes to the personal plan.			
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Not Compliant	Orange	30/11/2021
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	30/11/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/11/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	30/11/2021

Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/11/2021
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/08/2021