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 28
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	03 November 2021
Centre ID:	OSV-0005833
Fieldwork ID:	MON-0032826

About the designated centre

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

Designated Centre 28 is intended to provide full time residential services to no more than eight men with intellectual disability and high support needs. Designated Centre 28 is a two-storey house located on a campus in Palmerstown. Each resident has their own private bedroom. There are two communal sitting rooms and dining rooms, a sun room and two kitchens in the designated centre along with two shower rooms, four toilets and an office. Healthcare supports are provided by medical doctors, for example General Practitioners (GP) and psychiatrists as required. Residents also have access to allied health professionals such as physiotherapists, psychologists, occupational therapists, speech and language therapists and social workers. Nursing supports are available within the designated centre and the centre is staffed by staff nurses and care assistants. The whole time equivalent staffing for this designated centre is 13.4. The staff team are supervised and managed by a full time person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 November 2021	09:35hrs to 17:30hrs	Ciara McShane	Lead
Wednesday 3 November 2021	09:35hrs to 17:30hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

Inspectors adhered to public health measures including physical distancing measures and wore face masks at all times during the inspection.

Inspectors met all eight residents during the course of the inspection. All eight residents were at home at the time of the inspection, some residents were up and ready for the day while a small number of residents were being supported with personal care. Residents that were up and dressed were either sitting in the lounge area or having their breakfast.

Some residents spoke with the inspectors and gave their views on the service they received. One resident told inspectors that they did not like living in the centre as there was too much noise. They told inspectors that they would prefer to live in the "community" so that they could go on more outings. The resident told the inspector that they enjoyed going out in their community and particularly liked going to the pub. Their bedroom was decorated to their taste and the resident said they were very happy with it. The resident also showed the inspector a safety device that they used to alert staff if they needed support. They said they get on well with staff working in the centre. Inspectors observed interactions between the resident and the person in charge to be very familiar, respectful and good humoured.

A second resident also spoke to inspectors. This resident also told inspectors that they would like to move to the 'community'. The resident told inspectors that their day service ceased during COVID-19 and had not resumed. No alternative day service or regular provision of meaningful activities has been provided to the resident. During the inspection, the resident was observed to go for short walks on the campus grounds, watch television in their bedroom, and intermittently talk to staff and the inspectors. Inspectors observed a warm rapport between the resident and staff members. The resident appeared very comfortable and relaxed in the presence of staff. The resident was also looking forward to an outing with the staff nurse in a few days time to a local shopping centre as they had not been there in sometime.

Inspectors spoke to several members of staff during the inspection. At the commencement of the inspection the person in charge was not present, a staff nurse who was the shift lead facilitated most of the inspection. The person in charge was not on duty, they were on a rostered day off, but chose to come to the centre to met the inspectors. Inspectors found staff to be very knowledgeable of the needs of all of the residents. Staff were very open and honest in their views of the service and of the quality and care provided to residents. Staff expressed concern over the staffing levels and how this adversely impacted on the residents. The staffing levels in the centre were not adequate to meet the holistic needs of the residents. Due to the low staffing levels, the inspectors observed the staff on duty prioritised task orientated care and were unable to support all residents with meaningful activities. On the day of the inspection, most of residents' activities were campus or centre

based; one resident went to the local supermarket.

After an initial introductory meeting a staff member accompanied the inspectors on a walk around of the centre. The inspectors observed the layout and operation of the centre to be institutional in nature. Significant and concentrated cleaning and renovation was required throughout the centre. While the residents' bedrooms were personalised to their tastes and preferences, other areas of the centre were untidy, dirty, and damaged. For example, soft furnishings required repair, dirt was ingrained on floors and skirting boards, dust and cobwebs were seen throughout the centre, food debris was on kitchen surfaces, appliances, presses and floors, wall mounted hand-santiser units were causing the walls to become very marked and untidy due to excess spillages, there was damage to walls, and painting and renovation was required. The poor state of repair, poor cleanliness of the centre and the absence of robust infection prevention and control measures posed a risk to the safety and well-being of residents. These findings are further discussed in the quality and safety section of the report.

The inspectors observed the environment to be very noisy at times. Some residents displayed very loud vocalisations that could be heard throughout the centre. In addition to the loud vocalisation an alarm also activated several times during the morning and mid-afternoon. The alarm was to alert staff that a fire alarm had activated in another centre on the campus. The noise levels were not conducive to a relaxed and homely environment. A number of residents told inspectors that they were not happy with the noise; and some staff members told inspectors that the noise could distress residents to the point of them requiring chemical intervention, inspectors saw documented evidence of this practice.

The inspectors observed residents personal information displayed in common areas throughout the centre. Inspectors also overheard a staff member refer to a resident's personal care need in the presence of other residents and staff. This was not respectful of the resident's privacy and dignity. Inspectors observed laundry belonging to multiple residents to be stored in one residents bedroom and main meals were supplied by a central kitchen. Although staff were seen making residents breakfast and snacks from the centre's kitchen. However, overall a number of the practices were symptomatic of the institutional nature of the centre which is discussed further in the report.

In summary, residents were not in receipt of an acceptable standard of care and support in this centre with a number of issues impacting on their lived experience. The next two sections of this report presents the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the

leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the inspectors found that the provider was not demonstrating they had the capacity and capability to provide a safe service to all residents. The provider failed to ensure the service provided was safe, effective, sufficiently resourced and monitored, or meeting residents' needs. It was also found the service provided was not reflective of a human rights and person centred approach to care and support.

While there was a defined management structure in place the inspectors found that the governance arrangements were poor and required significant review to ensure that deficits in service provision were self-identified, escalated and responded to accordingly. The findings from this inspection demonstrated the provider had failed to put appropriate and adequate management systems or arrangements in place to assure themselves that a quality and safe service was being delivered. The provider's failure to do this resulted in a service where multiple deficits, that negatively impacted residents, were found. The inspector's were not assured residents were receiving a safe effective service that met their individual or collective needs. There was a systemic failure by the provider to provide care and support in a manner that was safe or that was meeting the totality of residents' needs.

Subsequent to the inspection and as result of the poor findings, a regulatory decision was taken to issue a notice of proposed decision to cancel the registration of the designated centre under Section 51 of the Health Act (2007) as amended. This decision was made under the grounds as set out in Section 51 (2) (b) of the Health Act (2007) as amended which states that the Chief Inspector is of the opinion that the registered provider, Stewarts Care Ltd., is not a fit person to be the registered provider of the designated centre. This report will set out the findings and areas of significant non-compliance which led to this decision.

The systems in place to manage and oversee the effectiveness and quality of the service were significantly lacking. An annual review of the quality and safety of care and support in the centre was completed. The annual review included consultation with the residents and their families; however, it had failed to identify areas for improvement as outlined in this report such as the staffing and premises issues. Where findings had been identified in the annual review such as the residents unhappiness about the noise levels in the centre, the actions were not in a SMART (specific, measurable, achievable, realistic and timely) format and the findings had not been acted on appropriately by the provider.

The provider had not consistently completed bi-annual unannounced visits as required by the regulations. No six-monthly unannounced audits were completed in the second half of 2020 or in the first half of 2021. The inspectors were told that one was completed in October of this year, which was outside of the six month timeframe, but the report for this was not finalised. Furthermore a self assessment questionnaire issued by the Office of the Chief Inspector to the provider in August 2021 in relation to infection prevention and control had not been completed.

The person in charge and staff working at the centre discussed areas of concern and risk that required additional resources, such as additional staff and equipment such as wheelchairs. However, while staff were aware of these risks it was not evidenced that these issues were raised at provider level or where they were such as a business case which was submitted for additional resources the impact and lived experience of residents was not clear or captured. The business case for additional staffing resources was refused.

The inspectors spoke with the provider representative subsequent to the inspection who confirmed that areas of risk and concern had not been escalated to the provider, an example of this was the risk of aspiration and their level of discomfort associated with a resident's need for a new wheelchair. A referral had been made to the occupational therapy department, and at the time of inspection the resident was still waiting on funding to be approved for the new chair. This demonstrated further that the oversight arrangements which ensured the service provided was safe and effective, and assured the provider, were weak and required strengthening.

Inspectors found, from speaking with staff, that they were knowledgeable of the residents' needs and preferences and were observed to engage with residents in a warm manner. However, inspectors found that the staffing arrangements at the centre were inadequate and failed to meet residents' needs. The inspectors found there were an insufficient number of staff to meet the needs of residents. At the time of inspection four health care assistants and one staff nurse were rostered daily to support eight residents. Some of the residents were assessed as requiring 2:1 and 1:1 staff care. Staff were endeavouring to support residents to participate in meaningful activities; to the extent of, some staff coming in on their days off to accompany residents on outings.

There was one staff nurse on duty in the centre each day and a review of a sample of residents' plans indicated that their nursing needs were being met. There was one full time staff vacancy which was filled using the permanent staff or regular staff. However, it was found that on numerous occasions, weekly at a minimum, that there insufficient staff scheduled to work. This was further compounded on days where staff working in the centre were frequently redeployed at short notice to work in other designated centres on the campus. From a review of the roster it was evident the centre was frequently operating below the staff compliment outlined in its statement of purpose, some days as much as 50% less than if should be.

The vacancy and the practice of redeploying staff was having an adverse impact on the quality of service provided to residents. Care and support was task orientated and residents were not supported to avail of a meaningful day. The staffing issues were also impacting on the management of the centre, senior staff were limited in their time to undertake management tasks as they were required to work vacant health care assistant shifts. The staffing vacancy was further compounded by the fact the provider had not demonstrated that the assessed needs of the residents could be met even with a full staff compliment. Inspectors were informed that the provider was actively recruiting to fill the vacancies across its campus.

The person in charge maintained a planned and actual staff rota; however, the rota

did not reflect when staff were redeployed to work outside of the centre. Two new staff members commenced working in the centre approximately two months ago. The staff members have been unable to access the provider's online information system which contains all relevant resident information such as personal plans, safeguarding plans and risk assessments. These staff members were reliant on asking other staff members for guidance on residents assessed needs and corresponding plans and interventions. This poses a risk to the accurate and reliable provision of care to residents and on the staff members awareness of potential and actual risks. A review of the centres staff training logs found that some staff were due training in areas such as manual handling and management of actual and potential aggression (MAPA).

The centre did not have a directory of its residents for the inspectors to review.

The provider moved a resident into the centre which had lead to ongoing incompatibility issues and incidents. The provider had failed to adequately assess the compatibility of the residents, to live together, in advance of the move. The centre had a complaints procedure for residents but residents had not been supported to avail of it despite expressions of dissatisfaction with their service. The provider has identified two residents to move out of the centre to a more suitable environment; however; the transition plans were at a very early stage and there was no time-frame set for the moves.

Whilst, the use of most restrictive practices in the centre had been notified to the authority, the use of chemical restraint had not.

Regulation 15: Staffing

The registered provider had not ensured that the number of staff working in the centre was appropriate to the number and assessed needs of the residents. There was one staff vacancy and the frequent practice of redeploying staff to work in other centres was impinging on the quality and safety of care and support provided to residents.

The person in charge maintained a planned and actual roster which set out the roles and skill-mix of staff; however, the rota did not record when staff were redeployed to work in other centres.

Some staff members did not have access to residents' assessments, care plans, safeguarding plans, and relevant risk assessments, to guide their provision of care and support.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were due training in areas such as manual handling, and MAPA. This posed a risk to the quality of care and support they delivered to residents. In addition, not all staff members were able to support some residents on activities outside a close proximity of the centre due to been untrained in the administration of emergency medication.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider did not have a directory of residents with the information specified in Schedule 3 of the regulations.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the inspectors found that the provider was not demonstrating they had the capacity and capability to provide a safe service to all residents. The provider failed to ensure the service provided was safe, effective, sufficiently resourced and monitored, or meeting residents' needs. It was also found the service provided was not reflective of a human rights and person centred approach to care and support.

While there was a defined management structure in place the inspectors found that the governance arrangements were poor and required significant review to ensure that deficits in service provision were self-identified, escalated and responded to accordingly. The findings from this inspection demonstrated the provider had failed to put appropriate and adequate management systems or arrangements in place to assure themselves that a quality and safe service was being delivered. The provider's failure to do this resulted in a service where multiple deficits, that negatively impacted residents, were found. The inspectors were not assured residents were receiving a safe effective service that met their individual or collective needs. There was a systemic failure on the behalf of the provider to provide care and support in a manner that was safe or that was meeting the totality of residents' needs.

The provider had not demonstrated that the centre was resourced appropriately. Staffing vacancies were impacting on the quality and safety of care provided to residents. Residents did not have all required specialised equipment based on their

assessed need.

The centre was not maintained to an acceptable or safe standard of hygiene and repair. The centre was dirty in places and repairs were required throughout the centre. The management systems to ensure that the centre was safe, appropriate, consistent and effectively monitored were inadequate. Not all six-monthly unannounced audits had been undertaken, the annual review failed to identify areas for improvement, and self audits were not being completed. Where findings had been identified in the annual review such as the dissatisfaction of residents about the noise levels in the centre, these findings had not been acted on appropriately or recorded and dealt with as complaints. Risk to residents' safety and well-being had not been acted upon.

A formal compatibility assessment for residents had not been completed. Whilst the provider was developing transition plans for two residents, there was no agreed plan or set time-frame for when this would take place.

Judgment: Not compliant

Regulation 31: Notification of incidents

While the use of environmental restrictions had been notified to the Chief Inspector on a quarterly basis, the use of chemical restraint had not.

Judgment: Not compliant

Regulation 34: Complaints procedure

Residents had not been supported to avail of the complaints procedure despite consistent expressions of dissatisfaction with their service. Staff told the inspectors that residents complained regularly about the noise levels in the house and some residents at the time of inspection also told the inspectors about their dissatisfaction.

However, on review of the complaints folder this feedback, which some residents were regularly communicating was not being recorded as a complaint.

Judgment: Not compliant

Quality and safety

This section of the report details the quality and of service and how safe it was for the residents who lived in the designated centre. The inspectors were not assured that residents were receiving a quality service or that the service was managed in a way that identified all risks appropriately and mitigated risk in a timely manner. Areas of concern which were found on inspection and impacted residents included infection prevention control, risk management, general welfare and development in addition to poor findings related to residents' rights.

Subsequent to the inspection an urgent action was issued to the provider in relation to protection against infection. (The provider's response was to a good standard and commitments made to address the issues with a number of areas confirmed as being addressed). The inspection findings demonstrated that residents' needs, wishes and preferences were not at the core of the service provided nor did it drive quality improvement in the centre. There were considerable improvements required across most regulations reviewed on this inspection.

The centre was located on a campus based setting and was found to be institutional in nature despite efforts, by staff, to make it more homely. Inspectors observed residents to be comfortable and happy in staff company. Residents spoken with also told staff that they were happy with their staff. Staff were open and honest with inspectors and expressed concern for the residents' well-being. As discussed earlier in the report, the inspectors found the staffing arrangements were not sufficient to meet the residents' needs. This was impinging on their rights to access their community and to engage in activities meaningful to them.

One resident used to attend a day service which ceased operation due to the COVID-19 pandemic, when the day service did reopen a decision was made for the resident that they should retire early. However, no retirement plan had been put in place or formal programme that was structured or supporting the resident to meet a need which at the time of inspection was unmet. The resident had not been supported to explore attending other day services or community groups.

Residents were not receiving a quality service in line with their will and preference, and rights. Although residents had individual social and personal plans, the quality of plans required review to ensure that they were meaningful. Where meaningful goals had been identified, such as going for a massage on a regular basis in the community, they had not been facilitated. Other goals reviewed were not meaningful and were more task orientated such as attending a chiropody appointment or getting their hair cut. A sample of residents' daily plans (50% in total) found that there was a significantly low level of activity for residents with most spending their time within their home or completing campus based activities such as walks. For the four residents whose activity schedules were reviewed in detail, for the month of October, there was a total of seven community activities some of which were group based. This demonstrated that residents were not supported to be actively involved in their local community or supported to set and achieve goals that were meaningful and beneficial to their overall welfare and reflected a model of care that was institutional in nature. This was further compounded by the insufficient staff resources.

From a sample review of residents' healthcare plans and from speaking with the staff nurse it was evident that residents' healthcare needs were being met. Residents were supported by nurses who oversaw residents' health assessments and plans. Residents had been supported to engage in national screening programmes, and had multi-disciplinary team input as required.

The premises was a two-story house located on a campus based setting in Dublin West. While efforts had been made to make it homely the overall aesthetic was not homely and was institutional in nature. The centre was not maintained to an acceptable standard of cleanliness or maintained to a good standard of upkeep. Staff working in the centre had painted areas of the centre and had supported residents to decorate their bedrooms. The bedrooms were personalised and residents spoken with said they were happy with them. Common areas of the centre were dirty, damaged and posed infection prevention and control risks. The main kitchen was cluttered and untidy with surfaces not maintained in a way that could be thoroughly cleaned. The kitchenettes that were upstairs were unclean and had food debris in drawers, presses, on work-surfaces and on the floor. Fridges and freezers were found to be unclean and food was not stored appropriately for example, a carton of food was open, not sealed and or labelled as to when it was opened. This posed as a risk. Bathrooms were unclean and rust was seen on a number of radiators and well as peeling paint on ceilings and dirty vents. Windows were unclean and the outside areas were cluttered with broken items such as an old fridge drawer and rusted clothes hangers. Floors throughout the centre required attention as dirt was ingrained in them and one area of flooring in the main hall was lifting and posed a trip hazard.

The provider had not ensured that all residents were protected from all forms of abuse. While staff for the most part had up-to-date safeguarding training and some safeguarding plans were in place, they were ineffective as ultimately the group of residents were not all suited to live together and a compatibility issued remained. The provider had made a commitment to not have more than seven residents in any campus based setting, however, a resident moved into the centre at the end of 2020 which increased the numbers living together to eight. This resident moved into the centre in the absence of a compatibility assessment or assurances that the move was a good move for all involved. From the inspection findings it was evident that there were too many men living together all of whom had varying and complex needs. While safeguarding plans attempted to initiate some improvement with this incompatibility, the measures outlined involved keeping residents apart, inspectors saw that these measures were not occurring and were also restrictive in nature. Residents for the most part spent their time together downstairs.

The noise levels in the centre were at times loud and did not promote a relaxed or homely atmosphere. Two residents spoke to inspectors and said they wanted to move out of the centre, due to the noise levels and to be able to partake in more activities. Inspectors found that loud vocalisations exhibited by a resident caused distress to other residents. This on occasion had resulted in one resident requiring medication to help with their response to the noise which would be considered chemical restraint. As well as the loud vocalisations, an alarm activated a number of times throughout the day to alert staff of a fire alarm activating in another centre.

The alarm could be heard throughout the centre and exacerbated the noise levels.

While safeguarding concerns were known by staff and they were able to speak to them, adequate safeguarding plans were not in place for all residents. Furthermore, incidents of a safeguarding nature were not being documented. Overall, the provider had not taken sufficient or effective steps to ensure that residents lived in a suitable environment that was free from distress and failed to ensure their well-being was maintained. It was also unclear if a referral had been made to the national safeguarding office.

Residents' personal information such as care plans and fire evacuation plans were displayed in common areas. Personal recording charts were left unattended in common areas. While the care and support delivered by staff was generally warm and kind, inspectors overheard a staff member referring to elements of a resident's personal care in the presence of other residents; this did not respect the residents right to privacy and dignity. Residents' laundry was sent to a central laundry and inspectors observed clean laundry, belonging to all of the residents, stored in one resident's bedroom. Residents' main meals were cooked in a central kitchen; however, residents did have access to a variety of foods and alternative meals. An action from the centres previous inspection in relation to residents access to their finances was in progress; the centre had developed templates to support residents to access their finances however, this was at the commencement phase at the time of inspection.

Staff were completing COVID-19 symptoms checks and screening visitors coming to the centre. However, the centre did not have appropriate measures in place to prevent and control the potential transmission of COVID-19. Some COVID-19 related risk assessments were not specific to the centre and required update. There was no COVID-19 contingency plan for the centre and the self assessment questionnaire issued by the Chief Inspector in August 2021 had not been completed.

Regular fire drills were undertaken to test fire evacuation arrangements. There were emergency evacuation plans as well as individual fire evacuation plans for residents. Staff were completing fire checks; and fire prevention and fighting equipment was serviced by a competent person. The upstairs exit route was not a safe route due to the build up of leafs on its path. Inspectors found the integrity of some fire doors to be compromised, and one fire door did not have a self closing device to activate in the event of a fire. Inspectors required the provider to seek assurances from a competent person that the fire containment arrangements in the main living area were acceptable.

The centre had up-to-date medication management policy and procedures. Self-administration of medication assessments had been completed with residents. Some residents were prescribed PRN medicines (medication as required). Prescription sheets for PRN medicines indicated the dosages and maximum dose during a 24 hour period but did not indicate the minimum intervals of time between each dose. One resident was prescribed emergency medication for seizures; not all staff were trained in the administration of this medication and risk assessments had not been completed to outline what the level of risk was with all staff not being trained and

how it would be mitigated. Inspectors were told by staff that the lack of trained staff prevented the resident from going on excursions outside close proximity to the centre, thus restricting their freedom of movement and right to engage in meaningful activities. Oxygen was available in the centre for some residents. However, there was no guidance or direction on the administration of the oxygen to guide staff on its appropriate use.

Where required, positive behaviour support plans were in place. The plans were reviewed regularly with psychology input. Environmental restrictions were in place for two residents. The restrictions were based on an assessment of need, reviewed on a regular basis, and the frequency and length of time in use was recorded; to ensure that they were the least restrictive and only used when necessary. The restrictions were found to be effective in supporting the residents from the risk of falling. Chemical PRN medication was administered to a resident at times when they became distressed due to the behaviours of other residents in their home. This was not in line with best practice and it was not demonstrated that every effort had been made to alleviate the cause of the resident's distress or if alternative measures had been considered before the PRN was administered. It had also not been recorded as a being a chemical restraint.

Risk management was poor and the provider had failed to address several risks. Some residents required 2:1 care for certain activities of daily living while one resident required 1:1 care at all times; however, the staffing levels were not maintained to meet these requirements. The risk posed by poor infection prevention arrangements had not been addressed. The risk of harm to residents' well-being and an impingement on their human rights had not been addressed. Other risks such as the risk to a resident from using a wheelchair no longer suitable to them, and the risk of harm to a resident from having a seizure when outside close proximity to the centre had not been assessed. The trip hazard as a result of the lifting floor had not been assessed and the provider had moved a resident into the centre aware of the risk it presented to the other residents without appropriate measures to control the risk. Risk assessments in relation to COVID-19 were out-of-date and not in line with the most recent public health guidance such as visits from family members. In addition, not all incidents of behaviours of concern were being reported to allow the provider investigate and learn from these events.

Regulation 12: Personal possessions

Residents had their own bedrooms with adequate space to store their personal possessions and property.

The centre was at the infancy of progressing an action to support residents to access and manage their own finances.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The provider had not provided residents with sufficient access to occupation and recreational activities, or opportunities to participate in activities in accordance with their wishes.

There were poor assessments completed in relation to residents' preferences for general welfare and development. Where meaningful goals had been identified, such as going for a massage on a regular basis in the community, they had not been facilitated. Other goals reviewed were not meaningful and were more task orientated such as attending a chiropody appointment or getting their hair cut. A sample of residents' daily plans (50% in total) found that there was a significantly low level of activity for residents with most spending their time within their home or completing campus based activities such as walks. For the four residents whose activity schedules were reviewed in detail, for the month of October, there was a total of seven community activities some of which were group based. This demonstrated that residents were not supported to be actively involved in their local community or supported to set and achieve goals that were meaningful and beneficial to their overall welfare and reflected a model of care that was institutional in nature. This was further compounded by the insufficient staff resources.

The provider failed to support residents in accordance with their interests, capacities and developmental needs. One resident used to attend a day service which ceased operation due to the COVID-19 pandemic, when the day service did reopen a decision was made for the resident that they should retire early. However, no retirement plan had been put in place or formal programme that was structured or supporting the resident to meet a need which at the time of inspection was unmet. The resident had not been supported to explore attending other day services or community groups.

Judgment: Not compliant

Regulation 17: Premises

During the inspection the inspectors observed the designated centre to be unclean and requiring attention in the following areas;

- main kitchen and kitchenettes: Food splashes, food substance and sticky residue found on walls, on and inside cupboards doors, inside drawers, on tiles, on counter tops and on floors. An exposed pipe in a kitchenette had peeling paint and was rusting. The main kitchen was lacking in storage as items were stored on counter tops, on top of utilities and on top of presses. Fridges were observed to be unclean and the seal of one fridge was broken. The seal of one freezer was dirty. The main kitchen was in bad state of repair

and the presses required to be replaced; some of the presses appeared to be made of chipboard and could therefore not be thoroughly cleaned. The cutlery drawer was not clean. Equipment such as coffee making machines were dirty and had a layer of scum on them. There were food items in a fridge that were opened, not sealed or labelled correctly. Flooring in all kitchen areas had ingrained dirt on them. A dirty dish cloth was on the counter top in a kitchenette upstairs.

- seating in a number of lounge areas was torn and the fabric of some were unclean. A curtain pole had broken in half in one lounge area and the curtain was missing. Walls and skirting boards were damaged in lounge areas and painting was required. Flooring in all lounge areas had ingrained dirt on them. The floor was lifting significantly in one living area and therefore bacteria could colonise there as the floor cannot be cleaned thoroughly.
- a number of bathrooms were visibly dirty - there were cobwebs around the open frames of windows, vents were dirty with a build-up of dust, doors, walls and tiles were dirty and had splashes on them. There was blue-tack on the walls of some bathrooms, raw plugs were exposed in bathrooms were utilities were once mounted. A screw/nail was lying on the ground of a bathroom floor (upstairs). Radiators in a number of bathrooms were rusting and had chipped paint. Peeling paint on bathroom ceilings was observed and there was dirt ingrained in each bathroom floor around the edging. Broken joints on wall. In one bathroom, there was a footstool, with rusting legs and the rust had transferred onto the tiles.
- wallpaper in the downstairs hallway was torn.
- waste management in the centre was not informed by a risk based approach or considered the risks associated with waste disposal. In one bathroom there was a domestic bin being used to collect heavily soiled continence wear which was placed loosely in the bin. This practice posed a mode of potential transmission due to the fact that it was not sealed.
- entrance hall: the floor was heavily stained at the centre's main entry/exit point. The area to the left of the entry point was overcrowded with equipment, coats, and other items. The floor could therefore not be cleaned sufficiently and the area looked untidy. Window blinds were stained.
- outside of the centre: at the entrance to the centre there was a large number of rusted clothes hangers discarded. At the back of the centre there was a broken fridge container discarded and a number of sweeping brushes were strewn on the ground.
- in a storage room, boxes of supplies were stored on the floor therefore the floor could not be thoroughly cleaned.
- windows throughout the centre were dirty, in particular the Velux windows.

Overall, monitoring and oversight of cleaning systems were not effective at all times. Schedules had been marked as complete however, observations on day demonstrated differently. Cleaning checklists were not at all times completed. The centre was not maintained to a suitable standard of repair.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had failed to adequately identify and assess risks in the centre, and thus, implement measures to control the risks. For example:

- some residents required 2:1 care for certain activities of daily living while one resident required 1:1 care at all times; however, the staffing levels were not maintained to meet these requirements.
- the risk posed by poor infection prevention arrangements had not been addressed.
- the risk of harm to residents' well-being and an impingement on their human rights had not been addressed.
- other risks such as the risk to a resident from using a wheelchair no longer suitable to them, and the risk of harm to a resident from having a seizure when outside close proximity to the centre had not been assessed.
- the trip hazard as a result of the lifting floor had not been assessed and the provider had moved a resident into the centre aware of the risk it presented to the other residents without appropriate measures to control the risk.
- risk assessments in relation to COVID-19 were out-of-date and not in line with the most recent public health guidance such as visits from family members.
- in addition, not all incidents of behaviours of concern were being reported to allow the provider investigate and learn from events.

Judgment: Substantially compliant

Regulation 27: Protection against infection

As described under regulation 17, the centre was not found to be in an acceptable standard of cleanliness and repair. This was of particular concerns considering the ongoing health pandemic. This posed a risk of transmission of infections to residents, as well as being an unpleasant environment to live in. Surfaces, due to damage, could not be thoroughly cleaned which posed as a risk for bacteria to colonise.

Waste management was poor and posed a significant risk of acquiring a healthcare associated infection.

Improvements were required in relation to the management of COVID-19. A number of COVID-19 risk assessments required update. A COVID-19 contingency plan was not it place in spite of there being an outbreak at the centre in early 2020. The provider had not completed HIQA's self-assessment questionnaire in line with the Chief Inspector's guidance. The provider had not demonstrated adequate precautions to protect residents against infection.

Judgment: Not compliant

Regulation 28: Fire precautions

The centre had fire safety management systems and precautions in place but improvement was required.

- the upstairs exit route was not a safe route due to the build up of leafs on its path.
- inspectors found the integrity of some fire doors to be compromised
- one fire door did not have a self closing device to activate in the event of a fire.
- inspectors required the provider to seek assurances from a competent person that the fire containment arrangements in the main living area were acceptable.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Oxygen was available in the centre for some residents. There was no guidance or direction on the administration of the oxygen to guide staff on its appropriate use.

Residents were prescribed PRN medications. Prescription sheets for PRNs indicated the dosages and maximum dosages in a 24 hour period but did not indicate the minimum intervals between each dose.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

From a review of a sample of residents' assessment of needs it was evident that these were in place and reviewed on a regular basis however they were not at all times updated to reflect changes in need such as mobility difficulties.

Assessments for social preferences were inadequate, not person centred and in some cases there were no goals set for residents to work towards or achieve. Residents were not supported with occupation, education or areas of opportunity that would support their development.

The centre was not suitable to meet the collective needs of all residents due to

behaviours of concern and competing needs.

Judgment: Not compliant

Regulation 6: Health care

The provider had provided appropriate health care for each resident. The person in charge ensured that residents could avail of national health screening programmes, were receiving appropriate nursing care, and had access to multi-disciplinary services.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were developed for residents where required. The plans were regularly reviewed with psychology input. The use of two environmental restrictions was appropriately assessed, implemented, and reviewed.

Chemical PRN medication was administered to a resident at times when they became distressed due to the behaviours of other residents in their home. This was not in line with best practice and it was not demonstrated that every effort had been made to alleviate the cause of the resident's distress or if alternative measures had been considered before the PRN was administered.

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that all residents were protected from all forms of abuse. While staff were for the most part up-to-date with safeguarding training and some safeguarding plans were in place, they were ineffective as ultimately the group of residents were not all suited to live together and a compatibility issued remained. A resident moved into the centre at the end of last year in the absence of an adequate compatibility assessment or assurances that the move was a good move for all involved.

Furthermore the provider made a commitment to not have more than seven residents in any campus based setting, the most recent resident moving in increased the numbers to eight. It was evident that there were too many men living together

all of whom had varying and complex needs.

While safeguarding plans attempted to initiate some improvement with this incompatibility, the measures involved keeping residents apart, which as observed at the time of the inspection, was not occurring but was also restrictive in nature. Residents for the most part spent their time together downstairs.

While safeguarding concerns were known by staff and they were able to speak to them, adequate safeguarding plans were not in place for all residents. Furthermore incidents of a safeguarding nature were not being documented.

Overall, the provider had not taken sufficient or effective steps to ensure that residents lived in a suitable environment that was free from distress and failed to ensure their well-being was maintained. It was also unclear if a referral had been made to the national safeguarding office.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had not ensured that each resident had freedom to exercise choice and control in their daily lives. Staffing to meet the full needs of the residents was inadequate. Staff engaged in necessary task orientated care which impinged on their ability to support residents to access their communities and participate in activities meaningful to them. One staff was voluntarily coming in on their day off to support a resident on a social trip as it could not be facilitated on a day with normal staffing levels.

Residents also spoke to inspectors and expressed their wish to move to a home in the community to be able to access more outings and to be away from the noise in the centre. One resident can not go within in a certain distance from the centre without a nurse. Nurses were not always available to accompany the resident.

The centre was institutional in nature. Efforts had been made by the staff to make the centre more homely and the residents' bedrooms had been decorated to the residents tastes. However, inspectors observed resident's personal information displayed in common areas of the centre and overheard staff commenting on a resident's personal care need in the presence of other residents. Other practices of an institutional nature included frequent exposure to noise (from other residents and from fire alarms activating from other centres on the campus).

Practices and arrangements in the centre did not promote or uphold residents' right in relation to respect, dignity, privacy, and freedom of choice and control in their daily lives.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 28 OSV-0005833

Inspection ID: MON-0032826

Date of inspection: 03/11/2021

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:
An additional daily resource was been approved on 8th November 2021 to bring the overall staffing requirement in Designated Centre 28 to 1 Person in Charge, 2 Nurses and 15.96 Care Staff . There is 1 WTE Staff Nurse that works between this designated centre and another to provide cover within the designated centres as required.
Recruitment of a Social Care Worker is planned to replace 1 Care Staff and this will bring the overall staffing requirement to 1 Person in Charge, 2 Nurses 1 Social Care Worker and 14.96 Care Staff. Social Care Worker will commence by end of January 2022.
3 additional Care Staff to fulfill the above staffing requirement will begin on 13th December 2021.

Person in Charge will ensure that actual roster in the home reflects when staff are redeployed to other areas. Effectice immediately.
The Human Resource department have dedicated significant time to recruitment within resident services and there are a confirmed 17.56 WTE commencing between December and the end of January 2022. This will contribute to an increase in staffing levels across resident services and reduce the requirement to redeploy staff to other homes as required. Ongoing efforts are in place to fill the remaining deficits in residents services in early 2022. This will have a positive impact on this designated centre, the improvement of staffing across the organisation will help to prevent staff moves from occuring as redeployment of staff is only used as an measure to ensure all residents across the residential services receive a safe service.
All staff members have access to the relevant documentation needed to guide their provision of care effective immediately. Person in Charge to ensure all staff have eclipse training by January 2022.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Learning and Development Department provided support in the home for staff to authenticate HSELand accounts on 1st and 2nd December 2021 to ensure that all training can be scheduled and completed.

An online education programme on observing and responding to seizures has been launched on HSEland. All Stewarts staff have access to this training. This training includes all education requirements and assessment for non-nursing staff to manage and monitor residents with epilepsy, including administration of prescribed rescue medication. This will replace the classroom based education from Epilepsy Ireland to increase the availability, uptake and refresher option for staff. A SOP has been developed to support non-nursing staff to access and manage prescribed epilepsy rescue medication in designated centres. Person in Charge to ensure that all staff have completed this training by end of January 2022

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
An up to date directory of residents is available in this home. Completed 10th November 2021

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Director of Care – Residents Services is chairing a weekly compliance performance meeting with the Programme Manager and Person in Charge to track and monitor compliance and ensure that all actions are completed to a sufficient quality and standard, and within the timeframe stated.
The Director of Care - Residents Services is meeting with the Chief Executive/ Provider Nominee on a weekly basis to provide assurances that the improvements set out are achieved. Effective immediately.

Actions resulting from all audits including annual review, risk review, IPC audit, fire audit and registered provider unannounced audit will be added to the designated centre compliance tracker. The compliance tracker report and any immediate corrective actions will be presented to the Chief Executive/ Provider Nominee on a weekly basis until full compliance is achieved. Compliance trackers are also discussed at monthly Quality, Safety, Risk and Policy Sub Board Committee allowing the board oversight of compliance across the residential homes.
A Quality Officer has been placed in this home to help staff create a personal activity schedule for each resident. This will be based on in-home and community activities and will educate staff on how to create meaningful goals to help to fulfill each residents life. This will continue until January 2022.
Stewarts Care has increased the size of the Quality Office to now include a Senior Quality Officer and a Quality Officer who are both focussed on provider audit activity and the coordination of other audit activity such as risk, IPC and safeguarding.
A Social Care Worker is being recruited to replace 1 Care Staff and this will bring the overall staffing establishment to 1 Person in Charge, 2 Nurses 1 Social Care Worker and 14.96 Care Staff. Social Care Worker will commence by end of January 2022.
3 additional Care Staff to fulfill the above staffing requirement will begin on Monday 13th December 2021. These additional resiources will allow for one resident to receive 1 to 1 support which brings the noise levels in the house down. This creates a more homely environment for all residents.
Both residents who did not have the required specialised equipment have been assessed by Occupational Therapist and will receive the most appropriate equipment for their needs in approximately 6 weeks. Occupational Therapists have also provided interim advice to keep residents safe until most appropriate equipment is in place. Due to be completed by 15th January 2022.
Assistant Director of Nursing and Infection Control Nurse are undertaking audits of ten homes per week with feedback presented to both the Care Management Team and the Quality Office. All findings are recorded and prioritised on a shared management schedule for action by named responsible persons with commencement dates noted. Actions are also included on the compliance tracker for each Designated Centre. This Designated Centre was last visited by IPC nurse on 30th November 2021.
Household staff completed a deep clean on 4th, 5th and 6th of November 2021.
Household Manager completed an audit on 4th November 2021 and identified any outstanding issues and addressed those with household staff.
Household Manager was present in the home every day from the 8th – 12th of November 2021. During this time the Household Manager monitored work on a daily basis, addressed cleaning work that was not up to standard and put additional household staff into area.

PIC to audit cleaning schedules on a weekly basis to ensure that a high standard is maintained. Nurse in charge on a daily basis should ensure that these are completed and any deficits in hygiene are addressed effectively.

Additional six monthly unnanounced audit took place on 1st December 2021 to provide a continuous governance oversight in the Designated Centre. Feedback was provided to the Registered Provider, Director of Care, Programme Manager and Person in Charge and entered into the compliance tracker.
Person in Charge will support staff in the designated centre to understand the complaints

policy to ensure that they can support the residents to make a complaint. Completed 19th November 2021.
In the weekly transition meetings the needs of the residents in this DC are priority on the agenda. Proposed location has been identified and a transition will take place by March 2022.
Important to note that a further transition of this resident in such a short period of time needs to be managed with extreme understanding of the resident in question as it needs to be person centered and also with their best interests in mind.

New transitions policy has been developed, which contains a compatibility assessment, and this will be used to support the resident's appropriate transition. This will be sent to all staff by 24th December 2021.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The use of PRN medication will be documented in line with the PRN protocol including the effectiveness. The Person in Charge will audit the use and documentation of PRN medication. Completed 22nd November 2021

The positive behaviour support plan has clear management strategies in place that identifies the non pharmalogical interventions that are to be implemented prior to the use of psychotropic medications and clearly identifies that medication should be utilised in accordance with the PRN protocol.
Psychology department to provide training on the implementation of the PBS plan and alternatives to use of PRN. The PBS plan lists alternatives to use of PRN and noted that PRN should only be used as a last resort and then only in reference to the PRN protocol in place. This will be completed by January 2022.
The PBS plan for resident to be examined in detail at the MDT on 06/12/2021 to explore any possible alternatives to PRN, not already in PBS plan that can be implemented. If new information or further alternative strategies, not already in the current plan, arise from this meeting, then the PBS plan will be further revised and updated.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Person in charge will ensure that all staff fully understand the complaints policy and have

read and signed the policy in order to fully understand the procedure that should take place. This will be completed by 1st December 2021.
Since inspection, the complaints process has been used effectively by staff and there are documented complaints coming into the complaints department from the residents of this designated centre. 19th November 2021

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Soldo cards are now being used in this home for both house costs and residents. Further training will be provided to the Person in Charge by the finance department by January 2022.
Management of Prepaid Cards for Service User Funds Policy was approved for sign off at the Quality, Safety, Risk and Policy Sub Board Committee on 02nd December 2021. This will be disseminated to all residential homes and Person in Charge will make all staff aware of this new policy. All staff will have read and signed the policy by 31st December 2021.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A quality officer has been placed in this home to help staff create a personal activity schedule for each resident. This will be based on in home and community activities and will educate staff on how to create meaningful goals to help to fulfill each residents lives. This will continue until January 2022.
Resident who expressed their preference to return to day services has returned. Commenced on 8th November 2021.
Day Service Manager is completing a will and preference survey with residents, to identify if there are residents who would like to return to a day service or those that would like a different model of day service than previous. Survey to be completed by 17th December 2021.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The information set out below is an update to the previous action plan provided to HIQA in relation to Regulation 17:

Household staff completed a deep clean on 4th, 5th and 6th of November 2021.
Household Manager completed an audit on 4th November 2021 and identified any outstanding issues and addressed those with household staff.
Household Manager was present in the home every day from the 8th – 12th of November 2021. During this time the Household Manager monitored work on a daily basis, addressed cleaning work that was not up to standard and put additional household staff into area.

PIC to audit cleaning schedules on a weekly basis to ensure that a high standard is maintained. Nurse in charge on a daily basis should ensure that these are completed and any deficits in hygiene are addressed effectively.

Exposed and peeling pipe was painted 26th November 2021.

The Person in Charge held a staff meeting on 5th November 2021 to highlight general housekeeping improvements including dirty bathrooms, leaving used cleaning cloths lying around, and to inform staff of where items should and should not be stored in a kitchen. All staff were made aware of these issues by 8th November 2021.

Technical Service Manager visited the home on the 5th of November 2021 and actioned the installation of new presses to provide better storage with new surfaces facilitating cleaning. This began on 12th November 2021. New storage cabinets were created, cabinet doors replaced, new counter tops installed in kitchen. Completed 12th November 2021

Seal of fridge was assessed on 5th November and is monitored by the IPC nurse and Household Manager to ensure appropriate cleaning of seal is taking place. Last IPC visit 30th December 2021.

A Learning and Development trainer visited this designated centre to deliver Food Safety training to staff in the home, in order to educate all staff on how food should be appropriately stored. This was completed on 10th November 2021.

Technical Service Manager has visited the home on the 5th November 2021 and approved the replacement of the kitchen floors. This work will begin by 31st January 2022.

New couches were delivered to this home on 26th of November 2021 and torn furniture was removed.

Broken curtain pole was removed and new curtains installed on 12th November 2021.

Technical Service team will repaint house and damage to walls skirting boards will be filled / repaired. New skirting boards to be installed if appropriate. This work will be completed by 31st January 2022.

Technical service team will replace the floor that was identified as lifting. Technical Service Manager will assess the other floors in this home for potential repair / replacement. This work will be completed by 31st January 2022.

Technical services have repaired walls with exposed plugs and affected bathroom tiles have been replaced. Completed 12th November 2021

Technical services team have reviewed all radiators in house and repairs were carried out where appropriate. Completed by 26th November 2021.

Broken joints on bathroom wall were removed and the wall repaired on 12th November 2021.

IPC Nurse assessed the bins in this home on 5th November 2021 and provided guidance to the Person in Charge on issues that needed to be raised with staff surrounding waste management.

Person in Charge addressed waste management in a documented staff meeting and ensured all staff are aware of their responsibilities regarding same. This included reminding staff that all incontinence wear needs to be bagged in a blue bag before being put in the bins and bins should be emptied regularly. This was completed by 8th November 2021.

The area at the bottom of the stairs has been tidied and all staff were made aware that this point should be kept clear and not used for storage.
Additional storage was provided upstairs on 12th November 2021.
Grounds department in conjunction with Technical Service Department ensured that all items discarded outside this home, to both front and rear, were removed on the 5th November 2021.

Person in Charge addressed monthly Health and Safety Audits that are completed by staff working in this home. Reminded all staff that these should be filled in appropriately and all issues should be highlighted on this and brought to management on a monthly basis. This was completed by 8th November 2021.

External window cleaning took place on 12th November 2021.

Person in Charge ensured that all of the resident COVID risk assessments have been reviewed and updated on 5th November 2021. The Risk Department in conjunction with the Person in Charge completed a full risk review of risk assessments in this home. This was completed by 30th November 2021.

COVID control team updated the organisational contingency plan to take into consideration the new Residential Care Facility guidelines and this was issued to all Persons in Charge by 12th November 2021.

In order to provide a greater oversight of overall monitoring the following took place;

Household Manager present in this home every day from the 8th – 12th of November 2021, monitoring staff cleaning checklists and highlighting inaccuracies and areas of concern. This continued on a weekly basis for 4 weeks after that.

IPC nurse reviewed this house weekly against previous IPC audits from 8th November 2021. Once furniture and kitchen presses were replaced a full IPC audit took place this was completed by 30th November 2021.

An additional Registered Provider Visit took place on the 1st December 2021 to ensure actions addressed in this action plan are being met.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
An onsite visit was completed in this designated centre with Head of Risk, Programme Manager and Person in Charge on 10th November 2021.
Four individual risk review meetings were held between Person in Charge and Head of Risk/ Risk Manager on the following dates: 10th November 2021, 16th November 2021, 26th November 2021 and 30th November 2021. Service user risk assessments were reviewed and updated, including a residents safeguarding concern affecting wellbeing of other residents, risk assessments for controlled epilepsy, Covid-19 and specialised seating. Service-level risk assessments were reviewed and updated on risk shared drive to include the four Regulation-26 risks, Covid-19, Fire, Choking, Slips/Trips and Falls and Safeguarding, with the Designated Centre risk register updated as required.
All incidents of behaviours of concern are currently being reported through the incident management system (SIMS) / Safeguarding pathway as appropriate to ensure adequate actions are taken to prevent recurrence, with HIQA notifications done as required.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Assistant Director of Nursing and Infection Control Nurse are undertaking audits of ten

homes per week with feedback presented to both the Care Management Team and the Quality Office. All findings are recorded and prioritised on a shared management schedule for action by named responsible persons with commencement dates noted. Actions are also included on the compliance tracker for each Designated Centre. This Designated Centre was last visited by IPC nurse on 30th November 2021.
Household staff completed a deep clean on 4th, 5th and 6th of November 2021.
Household Manager completed an audit on 4th November 2021 and identified any outstanding issues and addressed those with household staff.
Household Manager was present in the home every day from the 8th – 12th of November 2021. During this time the Household Manager monitored work on a daily basis, addressed cleaning work that was not up to standard and put additional household staff into area.

PIC to audit cleaning schedules including on a weekly basis to ensure that a high standard is maintained. Nurse in charge on a daily basis should ensure that these are completed and any deficits in hygiene are addressed effectively.

IPC Nurse assessed the bins in this home on 5th November 2021 and provided guidance to the Person in Charge on issues that needed to be raised with staff surrounding waste management.

Person in Charge addressed waste management in a documented staff meeting and ensured all staff are aware of their responsibilities regarding same. This included reminding staff that all incontinence wear needs to be bagged in a blue bag before being put in the bins and bins should be emptied regularly. Completed by 8th November 2021.

COVID control team updated the organisational contingency plan to take into consideration the new Residential Care Facility guidelines and this was issued to all Persons in Charge by 12th November 2021.
An up to date COVID-19 contingency plan is now in place in this designated centre 05th November 2021 and an updated Covid-19 service-level risk assessment is available 30th November 2021.
Person in Charge ensured that all of the resident COVID risk assessments have been reviewed and updated on 5th November 2021.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The upstairs exit route in this designated centre is now a safe route to move to a place of safety, or exit the building, in the event of fire. All leaves are now removed from the exit. The upstairs exit is clear and accessible. This is being continuously monitored.
Fire doors throughout the centre were reviewed and two fire doors were replaced on 23rd November 2021. Fire doors were also repaired on 23rd November 2021. Adequate fire doors along escape routes and high risk areas are in place and working effectively

and the integrity is now not compromised within the centre.

Self-closers were fitted on fire doors on the 23rd November 2021, which will activate in the event of fire. Magnetic hold open devices will be installed by 10th December 2021 by Chubb Ireland on two of the fire doors.

Adequate fire containment measures are in place within the main living area and will be reviewed regularly to ensure compliance.

Fire Safety Officer who holds a Bachelor of Science in Environmental, Health and Safety Management and has completed a Fire Safety Instructor course has visited the area 30th November 2021 and they have stated that the fire containment measures in the living area are acceptable.

Fire Safety Officer has visited the designated centre once per week during November 2021.

An unannounced Fire Safety Audit will be completed by the Fire Safety Officer during the week commencing Monday 6th December 2021, reviewing all fire precautions within this designated centre.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Oxygen is avilable in this home to be used at the nurses discretion in an emergency situation. An O2 therapy protocol is now available in the home and th Person in Charge will discuss this the staff nurses who work in this designated centre. Completed by 13th December 2021.
PRNs not stating the minimum intervals between each dose were charted for discussion at Drugs and Therapeutic Committee on 11th November 2021. Change to all PRN protocols confirmed, will now state time of duration between doses. This will commence immediately for completion by end of Dec 2021.

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:
The assessment of need will be updated to reflect the residents needs and will be discussed at Multi- Disciplinary Team meetings as a standing agenda item.
A Quality Officer has been placed in this home to help staff create a personal activity schedule for each resident. This will be based on in home and community activities and will educate staff on how to create meaningful goals to help to fulfill each resident's life. This will continue until January 2022.
Resident who expressed their preference to return to day services has returned. Commenced on 8th November 2021.
In the weekly transition meetings the needs of the residents in this designated centre are priority on the agenda. Proposed location has been identified and a transition will take place by March 2022

New transitions policy has been developed, which contains a compatibility assessment, and this will be used to support the resident's appropriate transition. This will be sent to all staff by 24th December 2021.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The positive behaviour support plan has clear management strategies in place that identifies the non pharmalogical interventions that are to be implemented prior to the use of psychotropic medications and clearly identifies that medication should be utilised in accordance with the PRN protocol.
The use of PRN medication will be documented in line with the PRN protocol including the effectiveness. The Person in Charge will audit the use and documentation of PRN medication. Completed 22nd November 2021
Psychology department to provide training on the implementation of the PBS plan and alternatives to use of PRN. The PBS plan lists alternatives to use of PRN and noted that PRN should only be used as a last resort and then only in reference to the PRN protocol in place. This will be completed by January 2022.
The PBS plan for resident to be examined in detail at the MDT on 06/12/2021 to explore any possible alternatives to PRN, not already in PBS plan that can be implemented. If new information or further alternative strategies, not already in the current plan, arise from this meeting, then the PBS plan will be further revised and updated.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The provider recognises that this transition was not appropriate and urgent measures have been put in place to reduce the numbers in this home A new Transition Policy was brought to the Quality, Safety, Risk and Policy Sub Board Committee for sign off on 02nd December 2021. This includes a compatibility assessment to be completed before any further transitions take place. It has been identified that there was under reporting of safeguarding incidents identified in this designated centre. There has been a very significant increase in the reporting of safeguarding incidents since November 2021. Safeguarding Manager has developed site specific safeguarding recording and reporting training for the area (power point presentation that can be delivered in person or virtually). This has been shared with the Person in Charge. Safeguarding Manager will also attend the staff meeting to provide further guidance to all staff on 8th and 10th December 2021. Safeguarding Manager met with the Person in Charge to review the current safeguarding plans 7th December 2021 3 additional Care Staff to fulfill the above staffing requirement will begin on Monday 13th December 2021. These additional resiources will allow for one resident to receive 1 to 1 support which brings the noise levels in the house down. This creates a more homely enviormonment for all residents.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The below approved staffing increases will allow for a greater lived experience of each resident in this designated centre. An additional daily resource was been approved on 8th November 2021 to bring the overall staffing requirement in Designated Centre 28 to 1 Person in Charge, 2 Nurses and 15.96 Care Staff . There is 1 WTE Staff Nurse that works between this designated centre and another to provide cover within the designated centres as required. Recruitment of a Social Care Worker is planned to replace 1 Care Staff and this will bring the overall staffing requirement to 1 Person in Charge, 2 Nurses 1 Social Care Worker and 14.96 Care Staff. Social Care Worker will commence by end of January 2022. 3 additional Care Staff to fulfill the above staffing requirement will begin on Monday 13th December 2021. These additional resiources will allow for one resident to receive 1 to 1 support which brings the noise levels in the house down. This creates a more homely enviormonment for all residents.	

In the weekly transition meetings the needs of the residents in this designated centre are priority on the agenda. Proposed location has been identified and a transition will take place by March 2022
New transitions policy has been developed, which contains a compatibility assessment, and this will be used to support the resident's appropriate transition. This will be sent to all staff by 24th December 2021.

By all staff completing the below identified training, there will not be the requirement for a nurse to be involved in all activities outside the home.

An online education programme on observing and responding to seizures has been launched on HSEland. All Stewarts staff have access to this training. This training includes all education requirements and assessment for non-nursing staff to manage and monitor residents with epilepsy, including administration of prescribed rescue medication. This will replace the classroom based education from Epilepsy Ireland to increase the availability, uptake and refresher option for staff. A standard operating procideure has been developed to support non-nursing staff to access and manage prescribed epilepsy rescue medication in designated centres. Person in Charge to ensure that all staff have completed this training by end of January 2022

Person in Charge to ensure staff complete GDPR training on HSEland to ensure all staff are aware of their responsibilities in ensuring residents personal information is stored in an appropriate location. All staff will complete this training by 31st January 2022.
To promote a more person centred approach in this designated centre a Quality Officer has been placed in this home to help staff create a personal activity schedule for each resident. This will be based on in home and community activities and will educate staff on how to create meningful goals to help to fulfill each resident's life. This will continue until January 2022.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	15/01/2022
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/12/2021
Regulation	The registered	Not Compliant		31/12/2021

13(2)(a)	provider shall provide the following for residents; access to facilities for occupation and recreation.		Orange	
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2021
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	31/12/2021
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Not Compliant	Orange	31/12/2021
Regulation 13(4)(b)	The person in charge shall ensure that where residents are in transition between services, continuity of education, training and	Not Compliant	Orange	31/12/2021

	employment is maintained.			
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	13/12/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	08/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the	Not Compliant	Red	28/02/2022

	number and needs of residents.			
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.	Not Compliant	Red	31/01/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(2)	The registered provider shall ensure that where the designated centre accommodates adults and children, sleeping accommodation is provided separately and decorated in an age-appropriate manner.	Not Compliant	Red	30/11/2021
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any	Not Compliant	Red	31/12/2021

	repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2022
Regulation 19(1)	The registered provider shall establish and maintain a directory of residents in the designated centre.	Not Compliant	Orange	15/11/2021
Regulation 19(2)	The directory established under paragraph (1) shall be made available, when requested, to the chief inspector.	Not Compliant	Orange	15/11/2021
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	15/11/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	13/12/2021
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	08/11/2021

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	28/02/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/12/2021
Regulation 26(2)	The registered provider shall	Substantially Compliant	Yellow	30/11/2021

	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.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Red	09/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/11/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/11/2021
Regulation	The person in	Substantially	Yellow	31/12/2021

29(4)(b)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Compliant		
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/12/2021
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of	Not Compliant	Orange	19/11/2021

	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(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/12/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/01/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in	Not Compliant	Red	31/01/2022

	accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	31/01/2022
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/01/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/01/2022
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	Substantially Compliant	Yellow	31/01/2022

	intervention techniques.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/11/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/11/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/11/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	31/01/2022

Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Substantially Compliant	Yellow	31/12/2021
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/11/2021