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 4
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	09 December 2020
Centre ID:	OSV-0005835
Fieldwork ID:	MON-0028429

About the designated centre

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

Designated Centre 4 aims to support and empower people with an intellectual disability to live meaningful and fulfilling lives by delivering quality, person-centred services, provided by a competent, skilled and caring workforce, in partnership with the person, their advocate, their family, the community, allied healthcare professional and statutory authorities. The centre consists of 3 separate detached houses in Kildare County. The centre can accommodate a maximum of 13 male or female adult residents. The centre is staffed by staff nurses, care staff and a person in charge,

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 9 December 2020	09:30hrs to 16:00hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In line with public health guidance and residents' assessed needs, the inspector did not spend extended periods of time with residents. However, the inspector did have the opportunity to meet with and speak to three residents during the inspection.

The inspector visited one of the three houses that comprises the designated centre. The inspector sat and spoke with two residents, in line with their assessed needs while following appropriate public health guidance. Residents told the inspector that they loved their home. However, a resident told the inspector that at times they felt unsafe, due to the behavioural support needs of a fellow resident. During these incidents, the resident said they would go to their bedroom which they referred to as their "safe space". The resident explained that they knew that these incidents were not intentional but they did make them feel afraid. The resident also told the inspector that while they would be comfortable telling familiar staff about their concerns, there were times when the staff working in the centre were unfamiliar and therefore they might not tell them if they were concerned. Another resident told the inspector that as they were independent within the community, they could leave the centre without staff support. They told the inspector they felt supported within the centre and they got on well with all their peers.

The inspector observed that residents had various communal spaces within the centre and this facilitated residents to leave their bedrooms and spend time in different parts of the centre. During the inspection, the inspector observed staff supporting residents with care and compassion.

Capacity and capability

This inspection found that the current governance and management arrangements within the centre were inadequate and this negatively impacted the capacity and capability of the centre. The arrangements within the centre did not ensure the delivery of high-quality, person-centred care and support. Significant improvements were required in staffing levels, to ensure residents' assessed needs could be met at all times.

The inspector found that the centre was managed by a suitably qualified, skilled and experienced person. The person in charge was found to have a good knowledge of the care and support requirements for residents living in the centre and was in a full time post. There was a management structure in place that identified lines of accountability and responsibility. However, the governance arrangements in place were not robust and this meant that the lines of accountability and responsibility were not clear. For instance while the provider had redeployed staff from another

part of the organisation to work permanently within the centre, these staff did not report to the person in charge directly. This led to the person in charge not having full oversight of staff annual leave or supervision arrangements. Additionally, the centres assurance mechanisms needed improvement. There had been no unannounced inspection of the centre on behalf of the provider in the previous six months. Furthermore, the annual review of quality and safety of care and support of the centre had been completed but required further enhancement to ensure it was in accordance with the standards.

During the inspection it was clear from a review of staff rotas that there was insufficient staff to meet the assessed need of residents. The provider had made a concerted effort to address the lack of staff by redeploying staff from other parts of the organisation, however the centre was still unable to provide sufficient staffing at all times. For example, for extended periods during the week, one part of the designated centre only had one staff member on duty. This led to residents assessed needs not being supported adequately and prevented residents accessing their community in line with their preferences. Furthermore, there was insufficient contingency arrangements in place to ensure staff continuity when staff were on planned or unexpected leave. This again negatively impacted residents assessed support needs. There was a planned and actual rota in place but it required improvement, as the current rota did not clearly identify the hours worked by each staff on duty. Throughout the inspection, the inspector engaged with staff and observed staff practice. The inspector found staff to be knowledgeable about their role and residents needs. Staff were observed supporting residents in a kind and compassionate manner during the inspection.

Staff were provided with suitable training such as fire safety, manual handling, positive behaviour support infection control. There were some gaps in this training but the provider was aware of these gaps and had made arrangements to address them and ensured all mandatory training was provided. The provider had a staff supervision system in place. However, this system required improvement as the person in charge did not have oversight of all staff supervision within the centre.

Regulation 15: Staffing

The staffing arrangements were not sufficient to meet the assessed needs of residents at all times. There was insufficient contingency arrangements in place to ensure staff continuity.The rota required improvement to ensure it was reflective of the hours each staff member worked.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date practice. However, not all appropriate refresher training had been completed.

Improvements were required in the provision of staff supervision, as the person in charge did not have oversight of all staff supervision within the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The cumulative impact of the non compliance identified across this inspection, demonstrated that the provider did not have sufficient governance and management arrangements in place to effectively monitor the centre.

The provider had not ensured that a written report on the safety and quality of care and support provided within the centre was completed every six months. The annual review of the quality and safety of care and support in the designated centre, was not completed in accordance with the standards.

Judgment: Not compliant

Quality and safety

Overall this inspection found that current arrangements within the centre adversely impacted the quality and safety of the centre. These arrangements led to some residents being exposed to persistent behaviours of concern, which at times left them feeling unsafe in the centre.

A review of documentation within the centre identified that there had been a high level of reoccurring behaviours of concern within the centre. For instance a resident had presented with 181 behavioural incidents in the previous 11 months. These incidents included self injurious behaviours, throwing objects, throwing furniture and shouting. These incidents were frequently observed by other residents living in the centre. A review of the residents' behaviour support plan highlighted the importance of a consistent and familiar staff team, however as already outlined, these resources were not always available within the centre. Additionally, the behaviour support plan also stated that in the event that deescalating techniques did not work, alternative restrictions, such as the use of PRN medicine (a medicine only taken as required) or physical restraint could be considered. However, these techniques were not authorised for use with this resident and therefore could not be used. This behaviour support plan required review to ensure staff were guided appropriately to

support the resident with their assessed needs.

The provider had systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. Staff had a good understanding of safeguarding processes and this limited the impact of potential safeguarding incidents. However, despite the person in charges best efforts, effective safeguards were not put in place to ensure all residents felt safe in the centre.

There were clear arrangements in place to protect residents and staff from acquiring or transmitting COVID-19. There were procedures in place for the prevention and control of infection. Suitable cleaning equipment was in place and stored appropriately. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. The provider had developed an appropriate COVID-19 contingency plan, which included adopting relevant public health guidance, such as daily staff temperature checks. The provider engaged regularly with the Department of Public Health and made key information in relation to infection control measures available to staff.

The provider had ensured that there were fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire. Regular fire drills were conducted within the centre.

The centre had a risk management policy in place for the assessment, management and ongoing review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. The person in charge and provider had ensured that pertinent risks were place on the register and were reviewed regularly. This included risk assessing the potential impact of residents and staff acquiring COVID-19, how to support residents to safely use their community and visiting relatives.

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified.

Judgment: Compliant

Regulation 27: Protection against infection

There were arrangements in place to protect residents from the risk of acquiring a

healthcare associated infection, including hand wash facilities, clinical waste arrangements and laundry facilities. The provider had introduced a range of measures to protect residents and staff from acquiring COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

There were appropriate systems in place for the prevention and detection of fire and all staff had received suitable training in fire prevention and emergency procedures.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The current arrangements in place within the centre did not ensure each residents' assessed needs were met.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was a high volume of reoccurring behaviours of concern within the centre and it was unclear if the measures put in place to address these concerns were effective. A residents behaviour support plan was not individualised sufficiently to ensure staff were guided in how to support them with their assessed needs.

Judgment: Not compliant

Regulation 8: Protection

Incidents, allegations, suspicions of abuse at the centre were investigated and reported but effective safeguards were not put in place to ensure all residents felt safe in the centre.

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 - 2015 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 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 4 OSV-0005835

Inspection ID: MON-0028429

Date of inspection: 09/12/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. A Familiar permanent staff WTE has being identified to move in to the DC commencing 25/01/2021 to fill a gap in the roster to ensure staff continuity. There is now a .50 HCA available to cover annual leave and sick leave. 2. The current computerised roster template will be reviewed with the work force manager and the TMS rostering group and the revised roster template roster will clearly identify the hours worked by each staff on duty. This will be completed by 31st Feburary 2021. 3. 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. This will be completed by the 25/01/2021. 4 .The assessment of need is being revised to ensure there are sufficient staff to meet the assessed needs of the residents in line with their preferences for community activities. This will be completed by the 31/03/20201 5. The programme manager PIC and Senior team member have had the first of monthly meetings on 19/01/2021 to ensure that the PIC has governance of day service staff and their supervision. These meeting will continue monthly FOR 2021. 6. The annual review of quality and safety of care and support is being reviewed and will be further enhanced to ensure it is in accordance with the standards.This will be completed by 30/06/2021.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and	

staff development:
1. The PIC has completed an audit of staff refresher training due. Training was very restricted in 2020 due to Covid19 control measure in place to reduce infection. Five staff requires Infection Prevention & Control .One staff member is is booked for 17/2/2021.The other four staff awaiting a date of confirmation. Five staff required manual handling refresher. They are awaiting confirmation of dates from education and training.
2 Four staff require fire safety awareness training. Two staff requires MAPPA one staff on long term sick leave for a year will complete train on her return end of February on return from sick leave. All Training will be completed by 30/07/2021

3 The Programme Manager will monitor PIC audit and progress of staff training at monthly meetings planned for 2021.

4 The programme manager PIC and Senior team members responsible for the New Direction day programme have met on 19/01/2021 .This will ensure systems are in place to ensure joint team working so that the PIC has governance of the day service staff and their supervision.These meeting will take place monthly with the programme manager to ensure the smooth seamless transition of the new direction day service programme.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Programme Manager has put in place a schedule of monthly meetings for 2021 with the Person in Charge, where all relevant issues in relation to the Governance of the Designated Centre will be reviewed.

2. The Programme Manager will collate a governance report for the Care Management Team on a monthly basis in 2021 where issues relating to the Designated Centre are discussed.

3. The provider has commissioned an external company to complete the Annual Review of Quality of Service for 2020 .This will combine the Regulations and the Standards and the Annual Review will be in line with the requirements of Regulation 23, of the Health Act (2007) Regulations (2013).This review is due for completion by 31/03/2021.

4. The Registered Provider Audits will be completed in the Designated Centre six monthly, from here on, in line with the requirements of Regulation 23.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The current Assessment of Need template will be revised by 31st January 2021 to ensure each residents assessed needs are met

2. All residents will be supported to complete the revised assessment of need with their keyworkers, and their circle of support and these will be completed by 30/06/2021 .The personal plan will be reviewed to ensure that it reflects the assessment of need and any identified actions are followed up.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The PIC and programme manager met with Psychologist on 16/01/21 to discuss the high volume of reoccurring behaviours of concerrns and if the measures put in place were adressing them effectivly .

2. The behavioural support plan that was insufficiently individualised will be amended and individualised to the residents assessed needs.

3. The psychologist will review the behavioural support plan to ensure staff are guided appropriatly to refer to the measures in place to support the residents assessed needs.This will be completed by 08th Feburary 2021

4. The psychologist with the support of Speech and Language Department will develop a training package and provide training to the staff team on the behavioural support plan and how to implement it effectivly .This training will involve support staff in the implementation of communication strategies social stories and visual cues.This will be completed by 31st Feburary 2021.

5. The Behavior Records of service users will be reviewed by the PIC after reported

incidents and on a weekly basis.

6. Behavior of concern and its management will be discussed at staff supervision and at monthly house meetings.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The PIC met with the safeguarding manager following inspection and revised the safeguarding plan based on the inspectors report. Based on the revelation by service user to the inspector during the visit The PIC/DO met with the safeguarding administration and submitted a revised FSP to CH07.

2. A response from CHO7 on 23/12/2020 identified acceptance of revised FSP and review due 05/05/2021.

3. An MDT team meeting will be scheduled by the PIC to discuss incidents and safeguarding concerns and review the compatibility of the residents in the Centre. This will include a comprehensive compatibility assessment and assessment of need. These assessments, together with consultations with the residents, will determine if the residents will continue to share accommodation into the future. This will be completed by the 29TH of February 2021.

4. The PIC has planned a premises review with the Technical Services Manager to assess if adaptations can be made to the premises , in order for the residents to live together safely if that is their wishes and preferences. This will be completed by 15TH April 2021.

5. The PIC and programme manager met with Psychologist on 16/01/21 to discuss feedback back from the inspection report.The behavioural support plan will be amended and individualised to the residents' assessed needs . The psychologist will review the behavioural support plan to ensure staff are guided appropriatly to support the residents' assessed needs.This will be completed by 8th February 2021.

6. The PIC and Programme manager met with the safeguarding manager on 16/01/21 to discuss feedback from the inspection report. The Safeguarding Manager will join a staff meeting for specific safeguarding with staff in the Centre. This will be completed by the 2nd February 2021.

7. The safeguarding manager will meet all residents in the Centre to get residents views on how they feel about living in the Centre and this will feed into the governance of the Centre. This will be completed by 2nd February 2021.

8. The behavior records of service users will be reviewed by the PIC after reported incidents and on a weekly basis.

9. The CNS in Behavior Support has recently commenced her role in Stewarts in January 2021 and is meeting the Programme Managers on 27/01/2021 to discuss the behavioral support documentation and review what training is required for staff.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	25/01/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	25/01/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	25/01/2021

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/03/2021
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	25/01/2021
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	25/01/2021
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	31/03/2021
Regulation	The registered	Not Compliant	Orange	30/06/2021

23(2)(a)	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.			
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 accordance with paragraph (1).	Not Compliant	Orange	31/03/2021
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.	Not Compliant	Orange	28/02/2021
Regulation 08(2)	The registered	Not Compliant		05/05/2021

	provider shall protect residents from all forms of abuse.		Orange	