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 26
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	04 and 05 April 2022
Centre ID:	OSV-0005839
Fieldwork ID:	MON-0027762

About the designated centre

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

Designated Centre 26 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 his family, the community, allied healthcare professional and statutory authorities. Designated Centre 26 is intended to provide long stay residential support for service users to no more than 8 men and/or women with complex support needs. Designated Centre 26 comprises of four separate homes Co Dublin. The centre is staffed by a person in charge, nurses, social care staff and healthcare assistants.

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
Monday 4 April 2022	09:45hrs to 17:10hrs	Louise Renwick	Lead
Tuesday 5 April 2022	09:30hrs to 14:40hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

There were eight residents living in the designated centre at the time of the inspection, across four different homes. The inspector visited three of the four homes over the course of two days and met five residents, some family members and members of the staff team. The inspector also spoke with members of the management and support team.

Following the inspection, the inspector was sent three questionnaires giving the views of residents, who had been supported to complete the written questionnaire with the help of staff. These had been completed with residents at the end of the previous year. Overall, the three questionnaires showed that residents for the most part were happy with their home and the support of the staff team. Some responses outlined that they were neither happy, nor unhappy with the amount of activities that they took part in, and two questionnaires outlined that residents felt more access to transport was needed. One questionnaire demonstrated that residents knew how to raise a complaint, but that they had not been happy with the outcome of their complaint regarding staffing or safety.

On arrival on the first morning of inspection to one of the homes, staff explained that residents were having a quiet morning, as they had been out the day before visiting museums in the city centre and attending sporting events which they had really enjoyed. There were three residents living in the home, two were being supported with personal care, and one resident was in bed. On arrival there were two staff members on duty, and staff explained that there were usually three but there had been unplanned staff absence that morning. This made it more difficult for staff to supervise one resident who was relaxing in the living room later in the morning, while also supporting other residents with their personal care needs, but staff were managing this well. Later on in the morning a staff member was assigned to work in this centre from another designated centre. Staff were planning on going through an induction with the staff member to assist them to understand residents' needs and the daily operation of the centre.

In speaking with residents, a resident told the inspector they were very happy since moving into this centre, they had previously been living in a campus setting in Palmerstown. The resident said that they liked the staff, there was nice food in the centre, and they liked their own bedroom and had a suitable wet room for their needs. The resident spoke about their wish to get a new mobility aid and asked staff about this during the day. This was being brought through the provider's allied health and social care professional team and referrals had been made, and staff kept the resident informed of this.

The inspector observed staff being friendly, warm and respectful with residents while supporting them, or speaking about them. Residents' choice in relation to their time to get up or get dressed was respected, for example, a resident who came to say hello to the inspector was in their pyjamas and communicated to staff that they

wished to go back to bed. In this home, staff were aware of how residents communicated through alternative methods, and were seen to understand residents' expressions and respond to them using lamh sign language to help them to understand.

This house of the designated centre had recently been decorated and refurbished with a new utility space, more open and accessible kitchen area, televisions in both living spaces and in residents' bedrooms. Downstairs there was an accessible bathroom. There were nice gardens around the house and residents told the inspector about some planting they had done of vegetables and plants. Staff did not have the use of a vehicle specifically for this home, but could request the use of car or bus from other homes within the centre when it was free. In recent weeks there had been an increased focus on providing meaningful activities.

In a second home of the designated centre, the inspector saw staff supporting residents in a kind and respectful manner. Staff explained that some residents required constant supervision. Staff were seen to explain things to residents as they were doing them, or to tell them information and residents demonstrated that these requests were understood. However, there were no tools, aids or communication supports in the home that would support residents who did not communicate verbally, to express themselves to staff. On review of some residents' information, and in speaking with staff the inspector saw that at times residents could behave in a way that was harmful to them, or posed a risk. The high supervision and engagement of staff in a one-to-one manner was to support this. However, for residents where this risk had been identified, there was no comprehensive behaviour support plan to outline the cause of the behaviour or give clear recommendations on how to proactively support residents. While their was sufficient staffing support to manage the risk of the behaviour, the resident had not been supported through a positive behaviour support plan to understand their behaviour and to identify the cause and possible needs that were not being met, for example, sensory needs or communication needs.

Some residents spoke with the inspector about their experience in the designated centre and explained that they liked the house and facilities, but they had some concerns about the service that they were receiving. The inspector spoke with residents about the supports they were offered, and the resident said that they did have access to a variety of external supports, but that they chose to refuse some supports offered. The resident disclosed to the inspector that they did not always feel comfortable with staff, and gave some examples of this. On review of the residents' daily notes, it was noted on a number of occasions that this had been raised through conversations with different staff members. However, this had not been dealt with as a potential complaint or a potential safeguarding issue.

The inspector reviewed the premises of the home, and was informed that the provider was working on a plan to widen the bedroom door exit off one resident's room and to get them a different type of bed, so that if a fire or emergency happened while they were resting they could leave quickly. While this was the plan that the provider was actively working on, residents expressed that at the moment, that they did not feel safe at night-time, in case there was a fire or an emergency

that needed an evacuation. On discussing this with staff, they were unclear on how they would practically complete an evacuation at night-time, as they were unable to re-enter the building if they did evacuate different residents separately.

One resident told the inspector about some of the things that staff did to help them, or keep them safe. For example, there was a new missing person profile and plan to be followed if the resident did not return to the centre, or if they didn't let staff know where they were. The resident also told the inspector that at times they chose to not follow these plans themselves, for example, by not answering their phone to tell staff that they were ok. The resident wished to make their own decisions and this was important to them. While the resident was making their own decisions and choices and this was being respected, these choices often placed the resident at risk.

On visiting the third home of the designated centre, the inspector met a staff member, reviewed documents and looked at the building. Both residents where out with staff for a day trip to Bray and were not present in the centre during the inspection. There was one staff in the home, who showed the inspector the house, documentation such as online and paper based care plans, rosters and audits. The staff member spoke to the inspector about residents, the way that the home was operated and their role.

The inspector saw a timetable board on the wall in the living room and was told this was to help residents. There were small black and white images to demonstrate different activities and places, which were kept in a plastic holder. However, there was no way to stick them onto the timetable wall. Residents positive behaviour support plans outlined a number of recommendations to support residents, for example a visual schedule of which staff members were working on the day. This was not in place, and staff were not aware if there was one available.

When arranging to visit the fourth home in the designated centre, the inspector was informed that no one was home. The resident and staff were out for the day, attending appointments and other activities. This home provided one-to-one staffing at all times, in line with the resident's assessed needs. From reviewing documentation and resident questionnaires, it was seen that the resident had self-directed activities and daily plans of their choosing with staff to support their choices and decisions. This home was a two-bedroom apartment with an open plan living/dining area and kitchen. Resident questionnaires reviewed outlined that the resident was very happy with their choice and control they had over their life. They lived alone and had staff to support them for all activities of choice.

Overall, the views of residents gained through observations, written questionnaires and conversations was positive in some aspects of their experience of the care and support that they received, for example, warm, kind support from the staff team, pleasant homely environments and increased access to meaningful activities. However, the experience of residents also further evidenced the requirement for improvements in relation to fire safety, the management of risk, complaint management and person-centred supports for people with behaviour that may

challenge.

The next two section of the report refers to the capacity and capability of the provider and the impact this had on the the quality and safety of the service provided to residents.

Capacity and capability

The provider did not demonstrate that they had the capacity and capability to govern and manage the designated centre in a manner that would ensure effective monitoring and oversight of the care and support delivered in the designated centre.

There were significant issues in relation to the governance and management of this designated centre, in the absence of the person in charge. Arrangements put in place had not ensured effective oversight of the designated centre in relation to the staffing resources, support for the staff team and management of escalated concerns or complaints and residents' supports.

The provider was applying to renew the registration of this centre, and had applied to renew the centre for eight residents. This centre was a community based designated centre, located in four separate homes in Dublin West. With three residents living in one home, two residents living in two homes and one resident living alone. There was a full-time person in charge, who was on leave at the time of the inspection and a staff team consisting of one part-time social care worker, two nurses, and 24 care assistant staff members.

The provider had management systems and tools across their organisation to support the monitoring of care and support in their designated centres, for example, six-monthly provider audits, audits and reviews for specific areas such as risk and infection prevention and control. Where these systems had identified gaps, they had not always brought about improvements. The provider's own auditing and review system had identified gaps in the designated centre, which were symptomatic of the deficits in relation to oversight, governance and management. For example, the poor recognition of complaints and management of same through the formal process, frequency of incidents requiring analysis and review to determine if they could be prevented, and the requirement for strong governance in relation to finances. Similarly, these audits identified gaps in the systems in place to promote better quality supports such as outstanding referral requirements for additional allied health and social care professional input and outstanding actions from specific audits, for example risk. While the auditing systems in place by the provider were identifying issues and areas for improvement, these were not seen to be appropriately acted upon in a timely manner or driving improvements in the quality of care.

The provider had configured the designated centre to consist of four separate homes across two geographical areas. This resulted in four different homes, with

four different staff teams under the responsibility of one person in charge. The size and layout of designated centre was not promoting cohesive oversight of the care and support being delivered to residents. For periods of time where the person in charge was absent from duty, the arrangements put in place by the provider to cover this responsibility had not been sufficient, with personnel responsible also holding remit over larger areas of responsibility.

Information gathered by the provider from different sources were conflicting, and not ensuring the provider had full oversight of the designated centre and its resources. For example, there was different information across the statement of purpose, provider's audits and management meetings to indicate what staff vacancies were in place. For example, audits identified two staff vacancies, management meetings noted 0.5 staff vacancies and stakeholders outlined that no vacancies were present. The information available to the provider was not being utilised effectively to continuously improve on the quality of care and support in the centre and this further demonstrated the lack of cohesive oversight in the centre specifically relating to staffing in this instance.

While the provider had determined an agreed staffing complement in the designated centre, it was not demonstrated that the centre was being managed in a way that ensured effective staffing levels and skill-mix was in place in each of the four homes and this impacted on the lived experience of residents. For example, at times when only two staff were present in one home, this resulted in residents not being able to leave their home during the day. In another home when one staff was on duty, daily notes from the previous weeks demonstrated that there were times noted where some residents had requested to use the bathroom or to go for a rest in bed and these could not be facilitated. The reason for this being noted that there was only one staff available.

The rosters reviewed of previous months demonstrated that on numerous occasions there had only been two staff on duty in one of the homes, and the minimum number of staff required to support residents outside of the centre was identified as three. Staff gave the inspector examples of the impact of reduced staffing in the centre, such as times when they had to bring a resident into their peer's bedroom so that they could support the second staff with an emergency situation. Staffing levels were determined in this centre as one-to-one for residents, so as to promote positive interactions between peers and to ensure all residents were kept safe from harm. The inspector was shown the agreed staffing allocations for this home by a member of the management team, which outlined that if all shifts were worked the centre was resourced for three staff each day up until 5pm, at which point it would reduce to two staff on duty for the remainder of the evening. While the provider was satisfied with the amount of staff allocated to work in this centre, they had not sought assurances that the management of their staffing resources and the absenteeism of staff was reducing the impact on residents' quality of care.

The statement of purpose outlined that this centre would have one whole time equivalent (WTE) social care worker and 0.5 WTE staff nurses. On discussing this with staff and management, it was determined that there was a part time social care worker, who worked in only one of the four homes. Nurses that were employed in

the centre worked shifts in particular homes and not in each location of the centre. Therefore, at times when the person in charge was not on duty, there were gaps in the informal supervision of the care staff teams across the four homes. The provider had plans to increase the social care worker role in the designated centre.

On reviewing the complaint logs in the designated centre, and from talking with residents, staff and family members it was not demonstrated that concerns or complaints raised were being recorded appropriately in order to ensure transparency and to allow for effective review in order to ensure people making complaints were satisfied with the outcome. This was noted in a resident questionnaire. While the inspector was aware that management were engaging in discussions with people who had raised complaints, these were not recorded in a manner that ensured complaints were managed in line with policy, and that there was appropriate review by persons not involved in the complaints. Where previous complaints had been formally raised and logged, there was insufficient evidence to show transparency around decision-making, or to demonstrate that complainants were satisfied. For example, allied health and social care professionals had raised concerns regarding staffing levels in previous years, records did not show how this had been reviewed and if the complainant was satisfied. In addition provider audits completed in 2022 identified issues that should have been raised as a complaint on behalf of residents or families. However, this had not been completed.

Overall, improvements were required to the use of information gathered through audits and reviews, the governance and oversight arrangements in the absence of the person in charge and the management of the staffing resources.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of the designated centre. This was received within the timeframe required.

On review of the footprint of the centre during the inspection, it was found that the floor plans submitted were not a true representation of the designated centre, as some changes had been made following building enhancements that were not reflective in the written floor plans.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The provider had appointed a new person in charge into the role in September 2021. The person in charge was not present during the inspection but from a review of documentation submitted was seen to have the required qualifications. The person in charge had adequate qualifications in social care and additional

qualifications in people management.

While the person in charge had previous experience in social care services, the provider had not submitted evidence of their three years experience in a supervisory or management role relevant to health and social care field. This had been requested prior to the inspection, but was not submitted.

Judgment: Substantially compliant

Regulation 15: Staffing

The staffing resources in the designated centre were not managed effectively to ensure adequate and consistent staffing support was planned and put in place at all times.

The planned and actual staff rosters did not demonstrate who was on duty for the week ahead. Actual rosters demonstrating who had worked in the centre showed an inadequate level of staff on a numbers of weeks reviewed. The provider could not demonstrate that they were managing their resources and rosters to ensure a safe number of staff were identified to work in the centre in the coming weeks, or that they had provided adequate staffing cover in the previous weeks reviewed.

On the day of inspection, some homes within the centre had absent staff which resulted in less than optimal number of staff available to support residents. The provider had made arrangements to cover this absence, and staffing was put in place from another designated centre later in the day to support the team. However, on review of the roster it was not evident who had been planned to work in the centre as only two shifts out of three had been identified for the day in question. Staff and residents did not always know which staff was due to work in the centre, and this did not promote continuity of care and predictability for residents.

It was not demonstrated that the provider had effective oversight of the staffing resources in the designated centre, how they were being managed and the impact this was having on the delivery of care and support to residents.

While the staffing numbers had been set by the provider, the skill-mix was still being fully considered at the time of the inspection. The provider had plans to increase the number of social care worker roles within the skill team, and to decrease the nursing support within the centre with access instead to a community nurse specialist for residents who did not require full-time nursing care. While the centre had been identified as requiring one social care worker, this role had only been recently filled with a part-time post.

Judgment: Not compliant

Regulation 16: Training and staff development

There were identified gaps in some mandatory training areas, some of which had been booked for staff in the coming weeks. For example, manual handing, fire safety and safe administration of medicine.

The provider had not identified the core training needs for this specific centre based on the individual needs of residents, for example training in dementia or training in supporting people with addiction or dependencies or mental health needs.

For staff who worked alone at night-time, the provider had not identified a requirement for staff to have training in emergency response or first aid training while working alone in community locations.

There was a formal system of supervision in place in the designated centre with one-to-one meetings between management and staff on a routine basis, in line with the provider's policy. There were gaps in the informal supervision of staff in the absence of the person in charge to ensure staff working in the four homes that make up the centre were appropriately supervised.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that there was effective management and oversight of a designated centre that consisted of four separate homes and four different staff teams across two geographical areas.

The provider had not ensured effective arrangements were in place for when the person in charge of the designated centre was absent from duties. The management structure required review to ensure there were clear lines of accountability and responsibility. The provider had plans to amend the role of the social care worker to hold more supervisory responsibility, however this had not been formally clarified and set out. Similarly, nursing roles which had defined responsibilities within the written statement of purpose were not fully applicable to the model of care being delivered in this designated centre.

The provider was not utilising information gathered from their audits, reviews and other information pathways to continuously identify issues and improve the quality and safety of care and support in the designated centre. Issues raised through the provider's monitoring systems had not been adequately addressed or planned for, for example, complaints were not effectively logged or followed up on, incidents required further review, there were actions outstanding from audits or checks and

residents' views regarding the impact of staffing on their daily plans.

The provider was not ensuring the resources in place in the designated centre were effectively managed and applied for the benefit of residents, in line with their assessed needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

Some improvements were required to the written Statement of Purpose and function to ensure the specific needs that could be catered for in the designated centre were outlined.

The whole time equivalent numbers of staffing in the designated centre were not in line with the staffing available in the designated centre on inspection.

The organisation structure and the lines of reporting and responsibilities of staff in the statement of purpose required review to ensure it was applicable to the model of care being delivered in this designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

While the provider had engaged with complainants regarding issues raised by residents, staff or family representatives, these had not all been recorded and processed in line with the provider's formal complaints process, to ensure transparency and effective review of their management.

Concerns or complaints raised locally by residents through conversations or questionnaires were not identified and managed through the complaint process to determine if complainants were satisfied with the outcome and actions taken by the provider or if they required further escalation or appeal.

Complaint logs in the designated centre were not up-to-date, to demonstrate local resolution, or escalation to formal process and review by an appropriate person to ensure complaints were responded to.

Judgment: Not compliant

Quality and safety

While staff were observed to be engaging with residents in a person-centred and respectful way, this inspection found that the quality and safety of the care and support provided to residents was predominately resource-led, and the provider was not operating the centre through a person-centred approach. Improvements were required in relation to assessing residents' needs, the practical management of risk, the provision of positive behaviour support and safeguarding.

The provider was given the opportunity to submit further information the day following the inspection, that had not been available during the course of the two days. These documents included certain risk assessments, safety protocols, evidence of team meetings, fire evacuation plans and resident questionnaires.

The provider also responded to two urgent actions given in relation to regulation 26, risk management and regulation 8, safeguarding. These actions were in relation to the low staffing levels in one home of the designated centre where there was only one staff member on duty at night-time and for long periods of time during the day to support two residents; some of whom required manual handing support to evacuate safely and risk in relation to safeguarding. Following the inspection, members of the provider's management and support team devised a clear written protocol for the evacuation of residents at night-time, should an emergency occur and ensured all staff had been fully informed of this. The provider also provided evidence of fire drill exercises that had taken place, with quick response times and evacuations demonstrated.

The provider's response also demonstrated that there were safety mechanisms in place to assess personal risk to residents and these had been completed with input from appropriate professionals, for example the safeguarding manager and other allied health and social care professionals. While this information was not readily available in the designated centre, the provider's response gave assurances that risks had been identified, and there were systems to assess such risks and protocols for staff to follow.

That being said, it was demonstrated that while there was a system for identifying and managing risk in the designated centre, this was not balanced with implementing adequate supports for people using the service. For example, the risks associated with residents' behaviour was assessed and measures put in place to try to manage this, but without effective supporting interventions to determine the cause and to create specific plans for residents. Similarly, while the risk associated with fire and safe evacuation was being assessed, and the provider was taking measures to manage this risk, it was not based on identifying the assessed needs and support requirements of residents. This was not promoting a proactive person-centred approach to risk management and resulted in negative findings across positive behaviour support, fire safety and safeguarding. While the provider was aiming to provide a safe service this was not balanced with ensuring there was a

good quality of the care and support being delivered.

Where risks had been identified due to residents' behaviour, these had been assessed using a formal risk assessment and control measures outlined. However, controls in practice while reducing certain risks were not fully promoting residents' needs. For example, to alleviate the risk of a particular behaviour, it was outlined that the resident had a positive behaviour support plan. On review of this document and in discussion with staff it was evident that there was an absence of a comprehensive support plan to positively support this. The function of this behaviour had not been determined, to ensure appropriate intervention from the correct allied health and social care professional, for example, a completed sensory assessment or a communication assessment.

Some residents communicated in alternative ways and did not communicate verbally. However there were no tools or equipment available to support all residents to express themselves or ensure their understanding when staff were communicating with them. For example, there was no visual displays, or objects of reference and staff did not use sign language. While staff told the inspector that residents understood them well, it was not demonstrated that residents had been supported to express their own communication effectively, in place of displaying behaviour that could be harmful to them. Some residents were supported with one-to-one supervision at all times, to prevent them from displaying problematic behaviour, for example, staff ensured that some residents was supervised even when using the bathroom and were only alone without supervision when they were sleeping. While the provider had ensured high level of staff support for some residents to reduce the risk, they had not ensured the cause of their behaviour was determined, as a way to reduce the level of supervision required and the impact this had on the residents' right to be alone, or have privacy.

The inspector was shown a living room in one home that was used as a sensory space, this room had rope lighting, black out blinds and bubble lights which residents enjoyed. Staff were not sure if residents had taken part in a sensory assessment, or if they had been referred for this. Behaviour support plans identified the cause of some behaviour as sensory seeking through a plan dated June 2021. While an email requesting input was sent in March 2022 to the allied health professional, this had not yet occurred. Similarly, where behaviour support plans outlined specific communication support tools for some residents, these were not seen to be in place.

For residents who did have a comprehensive behaviour support plan, it was found that recommendations within these plans were not fully implemented. For example, residents had not been assessed by relevant professionals when the cause of behaviour had been identified as requiring this. While behaviour had been assessed from a risk perspective, practices in the centre were focused on the management of the behaviour in place of positively supporting it.

The inspector was not assured that in the absence of a second staff at night-time in one of the homes, that the provider had robust, well-known and direct guidance for staff to follow in the event of a fire occurring while working alone. The provider

responded to an urgent action given after the inspection in relation to this.

While the provider demonstrated through additional information submitted, that numerous fire practice drills had taken place, that went well and resulted in everyone getting out of the building within a short period of time, this was dependent on the use of the ceiling hoist being used during an emergency. During the inspection, the inspector spoke with key personnel and was informed that the use of an electrical hoist during emergencies had not yet been considered or reviewed for potential risk, for example, to ensure that it had a back-up battery power, or was deemed safe to use with residents during all eventualities. Previously, the resident had a ski-pad in their room for evacuation from bed at night-time and this was noted in their personal evacuation plan. However, this was not currently in place due to the lack of clarity around if it was safe to use with only one staff member present.

Overall the risk associated with the evacuation of residents in one home of the centre had not been comprehensively assessed and planned for in line with resident's individual needs. The procedures that were put in place to promote residents to safely evacuate where based on the staffing resources available, and not what was the best option based on their individual needs.

While there was a system of assessing and planning for residents' health, social and personal needs, some improvements were required to ensure documents were updated, based on recent information and decisions and that plans were effectively reviewed to make sure that they were achieving what they set out to do. In general, healthcare needs were assessed by a staff nurse who wrote corresponding healthcare plans based on assessments. Personal, social and emotional needs were assessed through an assessment of need tool, along with additional assessments, if required from allied health and social care professionals employed by the provider. Residents had written personal support plans, and mini versions for residents to look through which were more accessible for them.

The provider was currently implementing a new online system for recording all information. During this change over, staff had been supported with paper based versions of some recording tools and access to previous information on the older system. During the inspection, certain information could not be accessed by staff in relation to residents' needs and plans, this was also a challenge for members of management. Of the plans reviewed online and on paper during the inspection, the inspector read some clear personal plans, that had good content on how to work with residents, what they liked and disliked and how to support their needs. However, information in some of the documents was outdated a number of years and required review as it was not consistent with the current practices in the designated centre or residents' daily lives.

Some paper-based documents that assisted new or existing staff to support residents' safety was limited in information, and did not include measures or protocols that were required to promote their safety, for example, what to do if a resident did not return home.

In general, healthcare plans were in place and offered guidance on different health needs. The guidance in healthcare plans to monitor for particular health issues required some improvement to offer greater clarity on frequency of monitoring, and who was responsible for monitoring them. For example, in a home where there were no nurses on the roster a resident required regular blood pressure checks to ensure no ill effect of medicine, with plans to alert their doctor if anything was unusual. However, plans did not specify how often this was to be done, or guide staff on what readings would indicate concern. For homes that did not require nursing support, further clarification and guidance was required to support the team in respect of monitoring residents' health needs.

Improvements were found to be required in relation to the general welfare and development of residents. It was found that some residents had more active lives than others. The frequency and quality of meaningful activities for residents were dependent on the staffing resources available in each home, each day. Staff were actively trying to provide improve meaningful activities for residents. In one home, a resident was supported with one-to-one staffing each day, resident questionnaire outlined that they were happy with the choice and control they had in their daily life and the activities and daily plans they had in place, for example, going to watch sporting matches locally or visiting pubs and restaurants. In another home for three residents, staff spoke with the inspector about the things that residents loved to do. From reviewing key worker meeting notes it was clear that in recent weeks residents had been supported to take part more in more activities, which they were really enjoying. For example, visiting parks, cultural places of interest and live sporting events in the city centre. In another home for two residents, when the required number of staff were in place, residents had access to a vehicle and enjoyed going out for the day to visit places of interest, or have their meals outside of the centre. However, staff also spoke of the limitations on encouraging activities outside of the centre, if the required staffing was not in place, for example in the evening time. Residents in this home originally attended formal day services operated by the provider full-time during the week, and this had stopped during the COVID-19 Pandemic. Residents had not yet returned to their day services, or had their wishes determined in relation to this. In the other home where two residents lived, one resident was supported in a one-to-one manner, and enjoyed going for walks or accessing local amenities, but they had not yet returned to using some of the provider's sporting facilities that they had previously enjoyed. A second resident mainly directed their own daily plan or chose to spend time alone. Resident questionnaires for some resident outlined access to transport as something that they would like to see improved in the designated centre.

Improvements were required in relation to the identification of potential safeguarding concerns and supporting residents to develop skills in personal safety. The provider had followed the safeguarding process in 2021 regarding an allegation made by a resident, and a safeguarding plan put in place for an interim period, this had been closed off as no grounds of concern were identified. However, concerns had been raised by a resident since this time and there were no guidelines in place for staff to manage repeated conversations about this incident or further concerns or allegations that may be raised by the resident. While some concerns from residents were being logged on daily notes it hadn't resulted in further review or

screening in line with national policy. The safeguarding process was not being used effectively to screen issues, and determine if concerns were valid and to identify further individual supports that may be required for the resident or the team in managing this.

Some residents had not been supported to develop self-care skills in relation to areas of vulnerability that posed a safeguarding risk, for example, risk of financial abuse and debt. While risk assessments were in place for known risks in relation to some residents' personal choices, there were inadequate supports in place to encourage residents to develop their own self-care skills. While staff and management were offering repeated supports for some residents to assist them in their decision-making, when these were refused there remained a risk. Protocols were drawn up for staff to follow in the event of residents not returning to the centre, or making unwise decisions that put them at risk however these protocols did not fully reduce the likelihood of it happening again. Staff had not been given training in how to support people who may have dependency issues or mental health conditions or who may behave in self-neglectful ways. While residents' choices were being respected, a formal assessment of capacity had not yet taken place and the provider had not assessed if the designated centre could continue to meet all residents' needs.

Regulation 13: General welfare and development

In recent weeks, residents access to meaningful activities had much improved in some homes of the designated centre. Residents enjoyed using local services and amenities, keeping in touch with friends and family and spending time doing things that they enjoyed. For example, going to live sporting events, visiting museums and parks.

Some residents' access to full-time day services had stopped due to COVID-19 risks, and they were now supported from their home setting. Residents had not yet been supported to express their wishes regarding returning to different day services, or other facilities available to residents by the provider, such as the gym or swimming pool. This was still ongoing at the time of the inspection.

Residents access to occupation and meaningful activities, was dependent on consistent staffing, which was not always in place.

Judgment: Substantially compliant

Regulation 17: Premises

The four homes of the designated centre were located in community locations, close to local bus routes, amenities and community facilities. The designated centre was

seen to be kept in good repair and there were systems in place to identify issues that required maintenance or upkeep.

While there were some minor areas for improvement of decoration for the overall centre, these had been identified through provider's audit and plans were in place to address these. For example, painting a wall of the back garden, removal of old furniture and the painting of newly installed doors. The interior of some homes within the designated centre had been renovated to a good standard, for example by replacing flooring, painting and decorating and upgrading of facilities.

Residents living in the designated centre all had their own individual bedrooms, and residents who liked or needed to live alone were supported in individual environments. Equipment was available in each home based on the needs of residents, for example equipment for manual handing and mobility and accessible showering and bathing facilities. Some of the residents who spoke with the inspector said that they liked their home, it was comfortable and they were happy with the premises and equipment in place to support them.

Judgment: Compliant

Regulation 26: Risk management procedures

Following the inspection, the provider was requested to take urgent action to alleviate the risks in relation to the low staffing levels in one home of the designated centre, where there was only one staff member on duty at night-time and for long periods of time during the day to support two residents, some of whom require manual handing support to evacuate safely in the event of an emergency, or for personal care. The provider submitted adequate responses to the urgent risk outlining the measures they had taken to reduce this by developing a clearer evacuation plan, and ensuring all staff were fully aware of how to safely evacuate all residents in the event of an emergency at night-time.

There was a risk management policy in place in the designated centre. The provider maintained a risk register of known risks in the designated centre and in relation to personal risks for residents. While these systems were in place, the inspector was not assured that through the risk assessment process, all risks to residents were being effectively reduced or mitigated.

There remained a level of risk in the designated centre in relation to the behaviour and decisions of some residents that the provider was not demonstrating were effectively managed. While risks had been assessed and protocols were in place for staff to follow in the event of certain incidents, these measures did not reduce the actual risk of harm to the resident.

The provider was demonstrating a risk management system that was promoting residents and staff safety. However, some risk assessments were not fully considering the impact of controls on other aspects of residents' care. For example,

increasing supervision to manage risk which impacted on residents' right to be alone, or have more privacy, in place of proactively meeting residents' needs through comprehensive and multidisciplinary supports.

While the risk of lone-working staff had been assessed as low in the designated centre, this required further review. For example, at times staff working alone did not have their mandatory training up-to-date in key areas and this impacted on the actual risk in place. Staff who worked alone were not provided with basic training in emergency response or first aid.

Judgment: Not compliant

Regulation 27: Protection against infection

The inspector observed appropriate infection control practices in place in the centre, for example, on arrival to the designated centre there was a visitor sign in sheet and measures to check temperature of all people entering the building. There was hand sanitising facilities located around the premises and on immediate arrival into the centre.

The registered provider had put in place policies and procedures for the management of the risk of infections in the designated centre, which were guided by public health guidance and national standards. The specific risk of COVID-19 was assessed, and the provider had plans in place to support residents to self-isolate if they were required to.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fire safety systems in place in the designated centre and had an auditing system in place to review these measures and identify areas for improvement.

The fire panel in one of the homes required improvement to ensure that it was addressable by staff in identifying the location of a potential fire and to support their safe evacuation. In the absence of an addressable panel, there was written guidance for staff to follow to evacuate safely. The provider had a plan in place to upgrade fire safety systems across their services over the course of the year, and had submitted this plan to the office of the chief inspector prior to the inspection.

The provider had enhanced the fire containment measures in the designated centre, by installing additional fire doors in the downstairs area of one unit of the centre.

Staff were provided with training in fire safety, and practical fire drill exercises. Some staff required refresher training in fire safety at the time of the inspection.

The provider had a longer-term plan in place for one home of the designated centre to widen a fire exit and review equipment to improve the evacuation plan in the event of a fire at night-time. While the provider had improved the evacuation plans in one home of the designated centre to ensure timely evacuation, the procedure required further assessment to ensure in the event of a real fire equipment identified as required to evacuate was safe to use.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

There was a system in place for routinely assessing and planning for residents' health, personal and social care needs, with input from nursing staff and allied health and social care professionals. Some improvements were required to the documentation content to ensure it was based on the most up-to-date information and assessments and gave clear guidance to staff on their responsibilities.

It was not demonstrated through appropriate assessments that the designated centre could fully meet the needs of all residents living there, and as need or circumstances changed some residents required additional assessments that had not yet been carried out.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were not all supported through comprehensive assessments of their behaviour, and the full implementation of a behaviour support plan to positively manage their behaviour.

For residents who did have behaviour support plans in place, the recommendations within these documents were not fully in place, for example, input of specific therapists for intervention support and alternative communication tools.

For residents with identified risk behaviour, these had been risk assessed from an infection control perspective, but there was no written behaviour support plan to detail how the resident would be supported to understand their behaviour, the cause of it and seek appropriate intervention through a guiding written plan.

This resulted in some residents' behaviour being managed through high staff supervision. However, the route cause of behaviours, the additional supports and

interventions required for residents and the full implementation of recommendations were not in place.

While some residents had refused the input of allied health and social care professionals in relation to their behaviour, it was not demonstrated that staff working in the centre had been provided with clear guidance and information to proactively and positively support all residents living in the centre, with regards to their behaviour and potential mental health needs.

Judgment: Not compliant

Regulation 8: Protection

The provider had safeguarding policies and procedures in place in the designated centre, had identified designated officers to manage safeguarding concerns and staff were provided with training and refresher training in the protection of vulnerable adults.

As an urgent action following the inspection, the provider was requested to review information with the designated centre to ensure all potential safeguarding concerns, allegations or known safeguarding risks were appropriately identified and recorded, and reported in line with their policies. The provider submitted a response outlining the formal reporting measures that had been taken in 2021 in relation to an allegation previously raised and the risk assessment plans that supported it.

While the provider demonstrated that this incident had followed the safeguarding reporting and recording process previously, it was not demonstrated that the support framework for residents who may raise allegations were in place. Potential concerns were being noted, however the safeguarding process was not being used effectively to screen all allegations to determine their validity, and to identify additional supports for either the resident or the staff team in supporting this.

While some residents were deemed to have full independence, it was not demonstrated how this had been formally assessed in order to determine their levels of independence or capacity and identify any specific areas where they may require skill teaching in self-protection, self-care or safety awareness.

While the provider had risk assessed the level of risk in relation to some residents' independent choice-making and vulnerability, they were not ensuring effective supports were in place to promote their safety, or ensuring that this centre could fully meet residents' particular needs.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 26 OSV-0005839

Inspection ID: MON-0027762

Date of inspection: 04/04/2022 and 05/04/2022

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**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: All updated floor plans have since been submitted since this inspection. The floor plans now show a true reflection of the designated centre.	
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: A new person in charge has since commenced in the role in this Designated Centre since this inspection. This person in charge has 5 years' experience as a person in charge and had previously been the person in charge over 2 designated Centres. Due to the geographical distance between homes this person in charge will be only responsible for this designated centre.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	

A full review of the planned and actual rosters have since taken place by the new Person in charge. Monthly rosters are now provided by the person in charge going forward and these rosters are provided to the PPIM for oversight. 2 additional WTE social care workers have since commenced in 2 of the homes in addition to the .5 social care worker that was present during the inspection. Ongoing recruitment continues to fill one more .5 social care worker. Nursing support will be provided by our new community nursing team by the 01/09/2022 for residents who require nursing care. This support will be provided throughout the week and also at weekends. There was a deficit of 1.26 WTE before the 2 new social care workers commenced in this Designated Centre. There is now a plus .76 WTE staffing in the centre to provide relief cover for annual leave and unexpected leave

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The new person in charge will carry out a comprehensive training needs specific review to the needs of individual residents and relevant training, for example dementia or training in supporting people with addiction or dependencies or mental health needs will be completed by the 31/08/2022

The person in charge will review staff training records and identified outstanding training will be completed by 31/08/2022. The person in charge has arranged with learning and development to train lone working staff in basic emergency response/first aid. This training will be completed by 31/08/2022.
The Person in Charge will be supported by Social Care Workers appropriately in the homes that make up the Designated Centre in carrying out informal Staff supervision in the absence of the Person in Charge.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Since this inspection there is now a social care worker in 3 of the 4 homes. All social care workers will complete a relevant management course as well as person in charge training. They will support the person in charge in providing governance and management in each home and will also provide effective oversight along with the PPIM when the person in charge is absent.

All social care workers are provided with a formal contract that sets out their roles and responsibilities. The statement of Purpose for Designated centre 26 is currently been updated by the pic which sets out the specific roles and responsibilities of the social care worker.

All actions go on the compliance tracker and the new pic will review this with all social care staff and their PPIM on a weekly basis. Any actions that need to be escalated will be submitted by the pic on their CMT report which will then be added to the PM's CMT report for the DOC. The DOC will then submit their EMT report to the provider.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose is being updated by the new PIC and PPIM. The statement of purpose now includes the specific roles of staff and the whole time staffing equivalent. The organization structure and the lines of reporting and responsibilities of staff are clearly outlined in the updated statement of purpose. The SOP will set out the specific roles and responsibilities of the social care work.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Chair of Complaints to provide the previous person in charge with 1 to 1 training to understand the complaints process and how to support staff, residents and families who make both local and formal complaints. Completed by 30th June 2022.

Undocumented complaint at time of inspection has since been addressed.

The new and current person in charge fully understands the complaints process and is a member of the complaints committee.

The new 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 by 30/06/2022.

Up to date complaints log now available in each home in this designated centre, this is

regularly monitored by the Programme Manager. Completed on the 15/05/2022.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A will and preference survey was carried out for each resident who would have previously attended a day services pre covid. This was completed in November 2021. Residents could decide if they would like to return to their previous day service, have their day service from their home or a hybrid model of a day service with some days going to their day service and the remaining days having a day service from their home.

Only one resident wanted to return to their previous day service with arrangements put in place. However they regularly refuse this option and won't engage with the staff team and members of the MDT team on why they won't take up this option.

Access to facilities such as the gym and swimming has been open to all Designated centres for the past six months.

With a new person in charge, new social care workers and consistent staffing now in place there are no barriers to meaningful activities.

There are currently 2 buses between the 8 residents. There is also the option to book a bus from our transport manager and the use of public transport if required to support for outings.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk assessment for unexplained absence for a resident has been updated on the 18/05/2022. This includes a comprehensive protocol of unexplained absence following a series of MDT meetings. This protocol was revised and approved by the MDT, and includes a clear guideline for staff communication and escalation during periods of unexplained absence of the resident of concern.
The newly appointed PIC has completed a full review of risk assessments for all residents within the DC and these have been communicated to with staff. The focus on all risk

assessments is to ensure risks are being effectively reduced.
In relation to a resident of concern, the issue of their right to be alone and have more privacy was discussed in a MDT meeting held on 18/05/2022. Regular MDT support is provided to this resident. An application for independent advocacy input has additionally been submitted by the Social Worker for this resident.
The Psychologist, Occupational therapist and Social Worker meet with this resident on a regular basis.
The risk assessment for lone working staff has been revised by the PIC on 23/05/2022.
The PIC has met with the Learning and Development Department to refresh mandatory training for all staff concerned. The PIC has also organised basic training in emergency response for all staff concerned which will be completed by end of August 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
New external doors have been ordered for one of the homes and will be delivered before the end of June 2022. This will ensure all exit points are widened in this home to ensure safe evacuation for identified resident in the case of a fire.
All fire evacuation plans have been reviewed and updated for each home in the designated centre by the new person in charge.
There has been numerous of fire drills carried out after this inspection and these were all reviewed by the fire officer.
All staff who require refresher training will have this completed by the 30/06/2022.

The new pic has also identified new fire wardens for each home in the designated Centre.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A full review of documentation is currently happening with the new Eclipse system. New assessments are being developed across all four homes.
All assessment of needs are under review by the new person in charge with some already completed with MDT input.

SALT referral for communication support will be completed by the 30/05/2022 for residents who require same.

OT referral for sensory assessment will be completed by the 30/05/2022 for residents who require same.
PBSP review will be completed by the 30/06/2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
A referral has been submitted to positive behavior support plan for one resident for the completion of a functional assessment to address the issues raised by regulator. This was completed on 21/05/22. This resident is scheduled to be reviewed at the positive behaviour consultation clinic for initial review by the 30/06/2022.

A referral for two residents has been made for Occupational Therapy to address the sensory function of their behavior and to support the implementation of their positive behavior support plans. Will be Completed: 30/05/2022. Referral scheduled for review by 31/07/22

A referral for speech and language therapy for residents where support with alternative communication methods has been identified. 30/05/22

A guidance protocol to be completed to enable staff to support a residents identified need based on assessment of need and residents preference for support. 30/06/22

All staff to be trained in PBSP training by the 31/08/2022.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A full safeguarding audit will be completed by the safeguarding manager for the designated center on the 16/06/22. Through this audit the safeguarding process will be reviewed and supports identified will be provided for residents and the staff team

A full capacity assessment is nearly completed by the psychology department and will be completed in 30/06/2022.

Staff in the designated center who have outstanding safeguarding training will have this completed by the 30/06/22

All staff in the designated center will complete supporting people with addiction training by 31/08/2022.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	26/05/2022
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	26/05/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with	Substantially Compliant	Yellow	26/05/2022

	their interests, capacities and developmental needs.			
Regulation 14(3)(a)	A person who is appointed as person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have a minimum of 3 years' experience in a management or supervisory role in the area of health or social care.	Substantially Compliant	Yellow	26/05/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2022
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.	Substantially Compliant	Yellow	26/05/2022
Regulation 15(4)	The person in charge shall	Not Compliant	Orange	26/05/2022

	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.			
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	31/08/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/06/2022
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	26/05/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details	Not Compliant	Orange	26/05/2022

	responsibilities for all areas of service provision.			
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	26/05/2022
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Substantially Compliant	Yellow	18/05/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a	Not Compliant	Orange	06/04/2022

	system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/06/2022
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	30/06/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/06/2022
Regulation	The registered	Not Compliant	Orange	26/05/2022

34(2)(b)	provider shall ensure that all complaints are investigated promptly.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	30/06/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	26/05/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual	Substantially Compliant	Yellow	30/06/2022

	basis.			
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	30/06/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/06/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/06/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's	Not Compliant	Orange	31/07/2022

	behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	31/07/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	26/05/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	07/04/2022