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 29
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	08 December 2020
Centre ID:	OSV-0005845
Fieldwork ID:	MON-0028357

About the designated centre

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

Designated Centre 29 is intended to provide long stay residential support for service users to no more than four men and women with complex support needs. Designated Centre 29 comprises two wheelchair accessible apartments, located on a campus in West Dublin operated by Stewarts Care Limited. Designated Centre 29 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 is located near amenities and public transport. The centre is staffed by a person in charge and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Tuesday 8 December 2020	09:40hrs to 16:15hrs	Ciara McShane	Lead

What residents told us and what inspectors observed

Due to limited space in the centre, and in line with infection prevention and control guidelines, the inspector carried out the inspection from an office that was based outside of the designated centre. However, for the initial part of the inspection the inspector entered one of the two units that made up the designated centre.

The inspector ensured physical distancing measures were implemented during interactions with residents and staff and wore the appropriate personal protective equipment (PPE). The inspector spoke with two residents in one of the units and respected residents' choice regarding the level of engagement.

The inspector observed that residents appeared content at the time of the inspection. One resident was in the kitchen area interacting with music on a tablet. The inspector spoke with the resident and they told the inspector about their plans for the evening which involved attending an outdoor Christmas event. The resident told the inspector they liked the staff and that it was 'good' living there. The resident wished to show the inspector their room which they were very proud off.

The inspector briefly spoke to another resident who was in the lounge area watching television. They also appeared content and at ease with the staff and also looking forward to the planned festivities that evening.

The inspector reviewed two questionnaires that were completed by residents, with the support of staff. The questionnaires were generally positive, but referenced the inadequacy of the environment stating there was little private space for residents, with 'no place to sit with visitors' and commented on the limited space in general in the centre; 'a lovely space, but too small' and 'would like two sitting rooms'.

Capacity and capability

While aspects of good care was demonstrated and evident, it was found that the provider did not have the capacity to ensure the service provided was safe, effective and meeting the residents' needs at all times.

The centre was registered in December 2019 for four residents with a restrictive condition placed on the registration linked to the provider's centre improvement plan. It was found on this inspection that the provider was working through the plan, but had not achieved all outcomes as of the time of the inspection.

Whilst some of these were still within the providers' revised timeframe it was unclear what the provider's plan was to ensure achievement of these outcomes by the

timeframes outlined. For example, there was an action regarding the unsuitability of both premises and the need to transition residents, but there were no plans developed ensuring the achievement of this outcome. Other areas that were outlined as requiring action included an assessment of the skill mix of staff and at the time of inspection this had also not been completed. The plan and associated actions required a review by the provider to assure themselves of how the outcomes would be achieved and by when.

While it was found that the provider was aware of some of the key issues identified on inspection, as referenced in their annual review from 2019 and the six monthly unannounced visit in September 2020, the management systems were not sufficiently robust or effective, at a local level, in identifying a pathway to resolving the issues ensuring residents' needs were being met. For example, having a positive experience of their home environment and one that was free from harm.

While the inspector found there were local audits completed such as medication management, finance management and a review of staffs' training, it was not evident that all information was being used to drive improvement such as reviewing and analysing behavioural incidents in the centre. In tandem with this it was evident that not all notifications were made in line with the requirements of the Regulations; the inspector found a number of incidents that potentially met the threshold of causing harm as a result of repeated and ongoing negative peer-to-peer interactions. The person in charge had screened some of these incidents, however none had been notified to the office of the chief inspector. The provider also failed to notify the office of the chief inspector regarding a suspected outbreak of an infectious disease as required. This further demonstrated that the oversight arrangements of the centre were not effective.

The inspector found there were planned and actual rosters in place at the time of the inspection and that these were maintained. From a look back review it was found that the centre operated on a number of occasions below the required staffing levels, which at times impacted negatively on residents as seen recorded in behavioural incidents. The rota also required a review to ensure that the person in charge was detailed on the rota and the designation of each staff member and the hours worked by them were outlined. There was also no key to denote when staff were on leave such as sick leave, training leave or annual leave.

The person in charge was a registered nurse and was full-time at the time of inspection. Her post was to be supernumerary, but due to the associated difficulties of COVID-19 the person in charge often had to support the staff team. The person in charge had remit for one other designated centre.

The staff team consisted of health care assistants and were found for the most part to be suitably trained. There were some gaps in training that the person in charge had identified and was aware off. These gaps were attributed to COVID-19 and the person in charge was endeavouring to ensure the training was received. Staff received regular supervision, on a monthly basis, and where new staff were recruited probationary reviews were completed.

It was not evident that the skill mix or level of staff was appropriate to meet the needs of residents. The inspector was told, and observed from a review of residents' plans, that their needs were becoming more complex. The person in charge told the inspector that she had informal occasional support from a nurse of another designated centre. However, this arrangement was not formalised for this centre nor was it demonstrated what the level of need was. The provider, had identified that a review of the required skills for the centre was necessary as per the centre improvement plan. At the time of the inspection this had not occurred.

In terms of staffing levels, the residents' behavioural support plans outlined that each resident in one unit required two-to-one staffing, however this was not in place at the time of inspection. The person in charge told the inspector the support plans were out of date and required a review and that the residents no longer required two-to-one staffing.

Regulation 14: Persons in charge

The role of the person was full-time and she had the required qualifications and experience to meet the requirements of the role.

Judgment: Compliant

Regulation 15: Staffing

It was not evident that the staffing levels and skill mix were appropriate to the needs of residents. It was not evident that there was sufficient nursing support in the centre to meet the needs of residents.

There were occasions were only one staff was on duty which impacted on the continuity of care for residents.

While there was a planned and actual rota in place it was not maintained as outlined in the report.

Judgment: Not compliant

Regulation 16: Training and staff development

While for the most part staff had received the appropriate training, some gaps were identified;

- four staff had not completed all aspects of hand hygiene training

- one staff required fire awareness training

- one staff required management of actual or potential aggression (MAPA) training.

Staff were appropriately supervised and records were maintained to reflect this.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were some audits in place, in addition to an annual review, the management systems in place were not effective in ensuring the service provided to residents was safe, appropriate to residents' needs and effectively monitored.

The annual review for 2019 had been completed, however as required by the regulations it was not done so in accordance with the standards.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found a number of incidents that potentially met the threshold of causing harm as a result of repeated and ongoing negative peer to peer interactions. The person in charge had screened some of these incidents, however none had been notified to the office of the chief inspector.

The provider also failed to notify the office of the chief inspector regarding a suspected outbreak of an infectious disease as required.

Judgment: Not compliant

Quality and safety

On this inspection while it was demonstrated that residents' healthcare needs were, for the most part, met it was not demonstrated that all residents were in receipt of a quality service that met their assessed needs and ensured they had the best possible lived experience in the centre.

The inspector crossed the threshold of one of the two units that made up the designated centre which was situated on a large campus. While the unit was maintained well and appeared to be clean the space was limited for the two residents living there and the staff team supporting them. Each resident had their own bedroom, a shared bathroom, a lounge room and a small kitchen/dining area. The inspector found although it was maintained well and clean, from a review of all relevant records, from the perspective of residents' compatibility and in conversation with staff, the unit was not appropriate to meet the needs of residents. The provider themselves was aware of this and had identified that both residents should be transitioned from this unit.

From a review of behavioural incident forms and from speaking with the person in charge it was evident that residents were not at all times experiencing a positive living environment. In one unit, which was home to two residents, there were numerous incidents recorded that demonstrated the incompatibility of residents and involved ongoing negative verbal exchanges in addition to throwing objects at their fellow resident and/or staff.

As seen in records and in speaking with the person in charge it was evident that the residents were also unable to remain in each others company without the presence of staff. The incompatibility of residents was further compounded by the premises which was small in size and inadequately equipped to provide residents with personal space outside of their bedrooms to comfortably relax. Residents also identified this sentiment in the completed questionnaires. In addition to the size of the premises the location of it was also not homely, it was located at the entrance to a building where administration offices were located. The provider had commenced looking for alternative accommodation for the residents however, this was done in the absence of any consultation with the residents and/or their representatives and in the absence of any formal transition plan or discovery process. it was therefore unclear as to how the wishes, preferences and needs of the residents were being ascertained as part of the provider's transition plans. To this effect, the provider was requested at the time of inspection to provide an assurance report to the office of the chief inspector outlining how and when the transitions would be achieved.

The provider had put a safeguarding plan in place for one of the residents and all staff had received training in safeguarding of vulnerable adults however, it was not evident that the safeguarding plan was effective as the incidents were ongoing.

The inspector reviewed a sample of residents' personal plans which were maintained online. The inspector found that residents had annual medical reviews, good access to their general practitioner (GP) and for the most part good access to allied health professionals and a multi-disciplinary team. The inspector reviewed a resident's file who was at risk of falls and noted the staff team responded appropriately to an increase in falls with referrals made to their GP, occupational therapist (OT) and subsequently received further tests which supported the diagnosis and treatment of an ailment. The staff team were supporting the resident with this and at the time of inspection were awaiting the lifting of restrictions to purchase a suitable recliner for

the resident in addition to having their eyesight tested.

Residents had access to dietitian support however this was not at all times completed in a swift manner. For two residents it was noted that repeated referrals regarding an increase in weight had been made, in 2019, but residents at the time of inspection had not received an appointment.

Behaviour report plans were in place for residents where required. The inspector reviewed a sample of two behaviour support plans. While the content of the plan was clear such as reactive and proactive strategies the plans had initially been developed in August 2018 and were due a review August 2019. Despite numerous referrals made by the person in charge, at the time of inspection, the plans had not been reviewed. Futhermore the plans were not in line with the actual practice in the centre for example the staffing levels recommended by the plans were two to one staffing to resident ratio for each resident. However, this was not the practice and the inspector was told it was no longer required. The residents physical health had also changed since the initial development of the plan but this was not reflected in the plan due to the absence of a review.

There were systems in place to manage risk. A recently reviewed risk register was in place that detailed generic risks for the centre such as slips, trips and falls, the risk associated with behaviours of concerns in addition to COVID-19. The inspector also reviewed a sample of individualised risk assessment for residents which were sufficiently detailed and recently reviewed.

The inspector reviewed the incidents and accidents that occurred at the centre. From a review of minutes pertaining to a staff team meeting in November, a fall regarding a resident was highlighted however this was not recorded as an incident. The inspector was therefore not assured that all incidents and accidents were being recorded as required.

The inspector reviewed matters in relation to infection prevention and control in the centre. The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. A specific risk assessment had been developed to capture the provider's response should there be suspected or confirmed cases of COVID-19. The contingency plan in relation to the isolation of residents was detailed however it required a review to demonstrate what the provider's staffing contingency was for this centre. The person in charge had some arrangements in place in terms of staff such as consistent relief staff, however if the staff team became affected by COVID-19 it was not clear how the centre would be staffed.

The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in relation to this. There was a folder with information on COVID-19 infection control guidance and protocols for staff to implement while working in the centre and the inspector found that this was updated in line with the most recent versions of the guidance. Personal protective equipment (PPE) was in good supply and hand washing facilities were available in the centre with a good supply of hand soap and alcohol hand gels available also.

the person in charge told the inspector there was plentiful supplies of PPE and that this was not a concern. Each staff member and resident had their temperature checked daily as a further precaution.

Due to COVID-19 the residents were impacted in terms of their ability to socialise and carry out their day as they would have in more recent times. The day service for residents was not operational however staff were endeavoring to support residents as best they could. Residents engaged in new activities such as wood binding and were supported by staff to learn new skills such as beauty therapy. Residents went for walks and were supported to contact family and friends with the aid of tablets. The in inspector was also told about residents involvement with gardening such as growing tomatoes.

Regulation 13: General welfare and development

Considering the public health guidelines that the provider was strictly adhering to residents were being supported well. Residents were engaged in activities and were supported by staff to do so. It was evident that staff were being creative with residents and supported them to learn new skills during this time away from their day service and regular activities.

Judgment: Compliant

Regulation 17: Premises

Although the premises was maintained well and clean it was small in space and did not meet the needs of those residing there. It failed to meet all requirements as detailed in Schedule 6 such as adequate private and communal accommodation for residents, including adequate social, recreational and private accommodation.

Judgment: Not compliant

Regulation 26: Risk management procedures

There was a local risk register which detailed associated generic risks. Risk assessments were also completed and reviewed regularly for risks pertaining to each resident.

Accidents and incidents were recorded using an online system however the inspector was not assured that all incidents were being recorded.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Arrangements were in place for the protection against infection. The inspector found that there were appropriate facilities for hand hygiene, including hand gels and the person in charge stated there was plentiful supplies of PPE.

Staff were seen to wear appropriate PPE and were kept updated on the changing guidance related to COVID-19 as seen in the relevant information folder and also detailed in daily handover notes.

Temperatures for staff and residents were checked daily and enhanced cleaning schedules were in place.

A contingency plan was also outlined through the use of a detailed risk assessment related to COVID -19 however further detail in relation to staff contingency was required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had their needs assessed and for the most part were reviewed regularly.

The person in charge had made multiple referrals to access a review of two behaviour support plans that were effectively out-of-date since 2019. The review at the time of inspection had not occurred and whilst the person in charge had reviewed the plans locally with the staff team the impact for residents was that the behaviours were still ongoing.

Residents had an accessible version of their plan as seen in a resident's bedroom.

Judgment: Not compliant

Regulation 6: Health care

Each resident had a healthcare plan in place. From a review of sample healthcare plans it was evident that residents were well supported to achieve best possible

health and were linked in with their GP and allied health professionals.

Residents received screening, where appropriate, in line with the National Screening programme.

Improvements were required to ensure that where reviews were necessary, such as dietitian, that these were responded to in a timely manner.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where required residents had behavioural support plans in place.

Staff for the most part had up-to-date training in supporting residents with this regard.

Judgment: Compliant

Regulation 8: Protection

Staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Arrangements were in place to safeguard residents when they were receiving personal intimate care.

The inspector was not assured that the arrangements to safeguard residents, at all times, were appropriate due to the compatibility of residents and the frequency of peer to peer incidents in the centre.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

The provider had plans to transition residents as outlined in their centre improvement plan and as discussed with the inspector. The provider also informed the inspector that they had been actively looking to acquire a house for the residents. However, this was being completed in the absence of a transition plan or any formal discovery process with the residents and their representatives such

as family members or advocacy.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 29 OSV-0005845

Inspection ID: MON-0028357

Date of inspection: 08/12/2020

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: Action: There are currently 12.50 HCA working in DC 29. Staff member that was on long term sick leave has been replaced. There is now a .50 HCA available to cover annual leave and sick leave. An additional relief staff is also due to commence on the 13th of January to ensure there are no deficits in the DC. This relief staff will work between DC 29 and DC 23. Staff nurse currently working in DC 23 with PIC is also available to cover one shift a week in DC 29 to ensure there is sufficient nursing support in the centre. Date for Completion 13/01/2021	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Action: 1.All staff will complete new online safeguarding training by 28/02/21. 2 staff will complete an introduction to Children First by 30/01/21. The staff members due to attend MAPA have completed the online training and will do the practical course by the 30/04/21, subject to availability with COVID restrictions. All staff members have completed hand hygiene training on HSEland, 3 staff to complete the Practical Infection Control and hand hygiene training by the 31/03/21. One staff is due Fire Safety refresher training and will do so by 30/03/21. Each staff member has met with the PIC for formal	

supervision and were issued with updated training records for timely booking of refresher courses. The Person in Charge will continuously review the training requirements for staff in the centre along with the Programme Manager.
Date for completion: 30/04/21

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Programme Manager will have monthly meetings with the Person in Charge, where any issues in relation to the Designated Centre are highlighted. The Programme Manager will have monthly meetings with the Director of Care where issues in relation to the Designated Centre are highlighted, and can be actioned.
The Programme Manager will collate a governance report for the Care Management Team on a monthly basis where issues relating to the Designated Centre are discussed, with attendance at these meetings including Director of Care-Residential Services, all Residential Programme Managers, Director of Nursing, Head of Risk and Quality, Safeguarding Manager and Night Manager.
The Provider has commissioned an external company, Wolfe Improve, to complete the Annual Review for 2020, which will take both the Regulations and the Standards into account. This review has commenced, and is due for completion by 31/03/2021.
The Provider will continue to carry out Registered Provider Audits in accordance with the standards for 2021.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Action: The Person in Charge will ensure all notifiable incidents are sent to HIQA within 3 working days as per guidelines. In the absence of the Person In Charge, the Programme Manager will be informed and will complete the required notification. The missed NFO2 for a suspected Covid -19 case was completed on the 08/12/20, immediately following the inspection, on the direction of the inspector.

The Programme Manager will discuss safeguarding and reporting incidents with PIC through supervision before the 31/01/21. Programme Manager is notified at the same time as the PIC of any incidents. Programme Manager will follow up with PIC to ensure all incidents that are required to be reported within the 3 working days are reported on

time.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Action:
The Provider is aware that the premises is not suitable for the residents in one of the homes in the Centre. A transition plan is being developed to find alternative suitable accommodation for the residents by 31/03/2021.

See Regulation 25 section for further details.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Action:
The Person in charge will ensure all incidents are recorded for the identification of trends and learning. This has been discussed with staff during supervision and at area meetings.

PIC will review 24 hour reports and behaviour records at the start of each shift to ensure no potential incidents have been missed. All staff will have completed on line safeguarding training before 28th of February 2021. PIC to discuss the importance of reporting incidents through supervision for each staff and also through monthly house meetings. All incidents going forward to be printed with a folder developed for all incidents. The incident report, notification to HIQA and PSFO1 to be all kept together for each incident to ensure a clear tracking of incidents can be maintained.
The Programme Manager will ensure good governance and oversight by completing fortnightly reviews of safeguarding processes in the designated centre.
For the resident at risk of falls, Multi-Disciplinary Team support has been provided, including Occupational Therapy, Physiotherapy, Nursing and Medical.
The Safeguarding Manager together with PIC and Programme Manager have organised an area specific safeguarding training and this will be rolled out to all staff in DC 29 via Zoom on week beginning Monday 11/01/21.

Date for completion: 28/02/21

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Action:
There are currently 12.50 HCA working in DC 29. Staff member that was on long term sick leave has been replaced. There is a .50 HCA available to cover annual leave and sick leave. An additional relief staff is also due to commence on the 13th of January to ensure there are no deficits in the DC. This relief staff will work between DC 29 and DC 23. Since January 2021 some services have been reduced in our day service with staff re-deployed to areas that are below their DNA due to Covid.

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:
Action:
The current Assessment of Need template will be reviewed by 31st January to ensure it includes assessment of resident's skill development and educational needs.

All residents were supported to complete an assessment of need by their keyworkers, and their circle of support and these will be reviewed by 30/03/21. The personal plan will be reviewed to ensure that it reflects the assessment of need and identified actions are followed up. The Psychology department will review the residents Positive Behaviour Plans on the 26/01/21.

Date for Completion: 30/03/21

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Action:
A full Annual Medical review will be completed by 31/03/2021. A full MDT to include all

members of the MDT will be completed by 31/01/2021, where all healthcare needs of the residents will be reviewed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Action:

1. The Safeguarding Manager together with PIC and Programme Manager have organised an area specific safeguarding training and this will be rolled out to all staff in DC 29 via Zoom on week beginning Monday 11/01/21.
2. The Programme Manager will discuss safeguarding and reporting incidents with PIC through supervision before the 31/01/21.
3. An updated assessment of need will be completed for both residents by the members of the Multi-Disciplinary Team and this will include a comprehensive compatibility assessment, and an assessment of the accommodation needs of both residents. Both residents and / or their appointed representatives will be consulted as part of this process. These assessments, and consultation with the residents, will determine whether the residents will continue to share accommodation into the future. This will be completed by the 31st of January 2021.
4. On completion of assessment of need, the process for sourcing appropriate accommodation will recommence. This will be carried out by the Director of Corporate Services in conjunction with the Care Management Team. This will be completed by 31st March 2021. The residents and/or their representatives will be consulted and engaged with regarding any potential premises identified. Should the assessments outlined in number 1, above, indicate that the residents require separate accommodation, and need to share with other service users, the process of sourcing suitable accommodation may take longer.
5. Upon identification of suitable accommodation, a full business case will be prepared and submitted to the appropriate funder for funding, if required. If the transition is cost increasing, the transition will be reliant upon approval of funding

Regulation 25: Temporary absence, transition and discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
Action:

1. An updated assessment of need will be completed for both residents by the members of the Multi-Disciplinary Team and this will include a comprehensive compatibility assessment, and an assessment of the accommodation needs of both residents. Both residents and/or their appointed representatives will be consulted as part of this process. These assessments, and consultations with the residents, will determine whether the residents will continue to share accommodation into the future. This will be completed by the 31st of January 2021.
1. On completion of assessment of need, the process for sourcing appropriate accommodation will recommence. This will be carried out by the Director of Corporate Services in conjunction with the Care Management Team. This will be completed by 31st March 2021. The residents and/or their representatives will be consulted and engaged with regarding any potential premises identified. Should the assessments outlined in 1 above indicate that the residents require separate accommodation, and need to share with other service users, the process of sourcing suitable accommodation may take longer.
Upon identification of suitable accommodation, a full business case will be prepared and submitted to the appropriate funder for funding, if required. If the transition is cost increasing, the transition will be reliant upon approval of funding

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	13/01/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	13/01/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Substantially Compliant	Yellow	13/01/2021

	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	30/04/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2021
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	31/03/2021
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 25(3)(a)	The person in charge shall ensure that	Not Compliant	Orange	31/03/2021

	residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	28/02/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/01/2021
Regulation 31(1)(b)	The person in charge shall give the chief inspector notice in writing	Not Compliant	Orange	31/01/2021

	within 3 working days of the following adverse incidents occurring in the designated centre: an outbreak of any notifiable disease as identified and published by the Health Protection Surveillance Centre.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/01/2021
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/03/2021
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is	Substantially Compliant	Yellow	31/03/2021

	provided by the registered provider or by arrangement with the Executive.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2021