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:	Announced
Date of inspection:	21 June 2022
Centre ID:	OSV-0005845
Fieldwork ID:	MON-0028363

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 varying support needs. 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 comprises two apartments and is located near amenities and public transport. The centre is staffed by a person in charge, nurse, 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 (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 21 June 2022	08:45hrs to 17:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector wore a face mask during the inspection and maintained physical distancing as much as possible during interactions with residents and staff.

The centre comprised two apartments located on a large campus setting operated by the provider. The first apartment accommodated two residents and was on the ground floor of a large two-storey building that also contained offices. The apartment was accessed through the front foyer of the building. The apartment comprised a main bathroom, two bedrooms, a small kitchen, and a small sitting room, and provided limited living space for residents. At times during the inspection, there were two care assistants, one nurse, the person in charge, a household staff, and the inspector in the apartment as well as the two residents which resulted in a cramped environment. Areas of the apartment were also found to require some upkeep and cleaning.

The second apartment accommodated two residents in a single-storey terraced building. The apartment was found to be well maintained, bright and clean. It comprised two bedrooms, bathroom, and a large open plan area with a kitchen, dining facilities, sofas, and a staff station.

The inspector observed folders and files, some of which contained personal information, openly stored in communal areas of both apartments, for example, medicine charts were observed in an unlocked press in one apartment and on an open counter in the other apartment. These practices presented a risk to the privacy of residents and required reconsideration.

The inspector met three residents during the inspection. The residents briefly communicated with the inspector. One resident told the inspector that they liked living in the centre and was happy with their bedroom and living space. The resident said that the staff were "great", and told the inspector that they liked to go to the hairdresser, get their nails done, and go on day trips and outings. The resident said they liked the food in the centre and enjoyed getting occasional takeaways. The resident recently celebrated their birthday with a party.

In advance of the inspection, questionnaires were sent to residents seeking their views on aspects of the service provided to them, for example, the environment and their bedrooms, food and mealtimes, rights, visiting arrangements, activities, staffing, and their care and supports. Staff completed the questionnaires on behalf of the residents and the feedback was positive, indicating that residents were happy with the service provided to them. One questionnaire noted that a fence was required at the back garden of one apartment for privacy. The questionnaires listed some of the activities that the residents enjoyed such as going to the gym, swimming, eating out, going to the pub, shopping, and bus drives. On the day of inspection, two residents participated in community activities, and two residents had

centre based activities including in house massage treatments.

During the inspection, the inspector met care assistants, nursing staff, a member of the provider's quality team, and the person in charge. Staff wore appropriate face masks in line with current national guidance. Staff were observed interacting with residents in a respectful and kind manner. Staff spoken with also advised the inspector that in their opinion, the quality and safety of care provided to residents was good and they had no concerns. The nurse had very recently commenced in the centre on a part-time basis, and had responsibility for overseeing the healthcare needs of all four residents. The person in charge had also recently commenced working in the centre.

The inspector was not adequately assured that residents were receiving safe and effective care in line with their assessed needs as staff could not access some of the residents' health, personal and social care plans during the inspection. The inspector also found that some restrictive practices were implemented in the absence of a protocol, authorisation, or consent from the residents affected. It was also found that not all restrictive practices were notified to the chief inspector as required. These matters did not provide assurances that the oversight of the centre was adequate and are discussed further in the report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

There were management systems and arrangements in place to support the delivery of a safe, consistent and appropriate service to residents. However, the effectiveness of the systems and arrangements required improvement in the areas of governance and management, staffing, training and development, and the notification of incidents.

There was a clear management structure in the centre with associated lines of responsibility and authority. The person in charge commenced in their role in May 2022, and was based in the centre. The person in charge was supported in their role by a programme manager, who in turn reported to a Director of Care.

While the provider had implemented systems to monitor the quality and safety of care provided in the centre, improvements were required to strengthen these systems. Annual reviews had been carried out which consulted with residents, and there were audits areas such as infection prevention and control, and health and safety. Actions for improvement were identified and tracked on a compliance tracker by the person in charge. Six-monthly reports on the quality and safety of care and support provided in the centre had been carried out in 2022, however, there were no six-monthly reports for 2021. The absence of these reports in 2021,

demonstrated that the provider had not effectively monitored the centre during this time, particularly as the inspection of the centre in December 2020 had found poor levels of compliance across a number of regulations resulting in escalation activity that required the provider to make considerable improvements.

The staff skill-mix in the centre primarily consisted of care assistants. There was one part-time nurse working in the centre who worked between the apartments and had responsibility for the oversight of the residents health care needs. The inspector was advised that there was no relief nurses to cover the nurses leave which posed a risk to the quality of residents' care. The provider was planning to assess the skill-mix and complement in the centre to ensure that it met the assessed needs of the residents. The person in charge maintained a planned and actual staff rota. The inspector viewed a sample of the recent rotas and found that two care assistant staff were rostered during the day in each apartment. However, the inspector found that in one apartment, there were often vacant shifts that were not covered, for example, in June 2022, there were seven days when there was only one care assistant on duty. Staff spoken with advised the inspector that reduced staffing levels impacted on residents being supported to engaged in meaningful activities of their choice.

Staff working in the centre completed a suite of training as part of their professional development. The inspector viewed the staff training records maintained by the person in charge, and found that some staff required training in the following areas, fire safety, positive behaviour support, infection prevention and control, manual handling, and management of challenging behaviour. The person in charge was scheduling the outstanding training.

The person in charge provided informal and formal support and supervision to staff. Informal support and supervision was provided on a regular basis and formal supervision took place every three months. The person in charge maintained a supervision schedule and was up-to-date with the quarter two schedule. However, formal supervision had not taken place for all staff in quarter one, prior to the person in charge commencing, which posed a risk to the quality of care provided to residents. In the absence of the person in charge, staff reported to the programme manager, or nurse manager on-call if out of normal working hours. There were also regular team meetings that provided staff with an opportunity to raise any concerns. Staff spoken with advised the inspector that they were very satisfied with the support and supervision provided by the person in charge, and felt comfortable in raising any concerns.

The inspector found that not all restrictive procedures used in the centre had been notified to the Chief Inspector, for example, physical restraints.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was based in the centre, and appropriately qualified in social care and

management. The person in charge was relatively new to their role, however had supervisory and management experience from previous roles.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had provided a staff skill-mix primarily consisting of care assistants. There was one part-time nurse who worked between both apartments and had responsibility for overseeing residents' health care needs. The provider was planning on reviewing the staff skill-mix and complement to ensure that it was appropriate to the residents' assessed needs.

The person in charge maintained a planned and actual staff rota. The inspector found that some vacant shifts were not filled which impacted on the quality of service provided to residents, for example, from 1 to 20 June 2022, there was seven days when there was only one care assistant working in an apartment when the rota indicated that there should have been two.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff working in the centre had access to training as part of their continuous professional development and to support the delivery of effective care and support. The person in charge maintained training records, and the inspector found that some staff required training, including refresher training, in the following:

- Two staff required training in management of challenging behaviour
- Three staff required training in infection prevention and control
- Three staff required training in manual handling
- Nine staff require training in fire safety
- Thirteen staff required training in positive behaviour support

The person in charge was scheduling the outstanding training.

The person in charge was providing formal and informal supervision to staff. Formal supervision was carried out on a quarterly basis. The person in charge was carrying out the supervision for quarter two, however, not all of the supervision sessions due in quarter one had been completed. In the absence of the person in charge, staff were supported by the programme manager or nurse manager on-call.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clear management structure in the centre with associated lines of authority and responsibility.

The registered provider had implemented management systems to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. The systems included annual reviews, six-monthly reports, and audits on areas such as, health and safety, and infection prevention and control. The actions for improvement were maintained on a compliance tracker that was reviewed and updated by the person in charge to ensure progression and completion.

However, the provider's monitoring systems required improvement. There was no six-monthly report on the safety and quality of care and support provided in the centre carried out in 2021. The absence of these reports did not demonstrate that the monitoring systems were effective, especially as the inspection of the centre in December 2020 had found poor levels of compliance. Furthermore, the findings of this inspection indicated that the oversight systems require enhancement to ensure that the service provided in the centre was safe and effective, particularly in relation to residents' personal plans and on the use of restrictive procedures

Judgment: Not compliant

Regulation 31: Notification of incidents

The use of some restrictive practices, including chemical and physical restraints, had not been notified to the Chief Inspector at the end of the previous quarter.

Judgment: Not compliant

Quality and safety

This inspection found risks to the quality, effectiveness and safety of care and support provided to residents in the centre. Improvements were required under a number of areas including premises, communication, transitions, health care, fire precautions, protection against infection, and particularly in relation to residents' personal plans and the use of restraints.

The centre comprised two apartments located on the provider's campus setting. The first apartment was small. The centre was previously inspected in December 2020, and it was found that the apartment was unsuitable to meet the needs of the residents. Following that inspection, the provider submitted an improvement plan to the Chief Inspector which included a commitment to move the residents to a more appropriate home by 1 August 2022. Transition assessments were completed to identify the appropriate type of home for residents. The provider advised the inspector on the challenges in securing an appropriate premise. While a property has since been sourced, the provider advised the inspector that it is unlikely to be ready by 1 August 2022 for the residents to move into.

The inspector observed the apartment to be very limited in space due to its size, layout, and the number of persons present during the day. While efforts had been made to make the apartment more homely, parts of it remained institutional in aesthetic. The apartment was generally clean, but some upkeep and attention was required. The bedrooms were decorated to residents' tastes. One bedroom required a touch up of paint, the flooring and skirting boards were damaged, and the radiator paint was chipped. One resident used an electric bed, but there was no servicing records for the bed. The bedroom doors had small frosted windows, and consideration was required on how the windows may impact on the residents. In the bathroom, some of the shower tiles were chipped, and the storage of toothbrushes presented a risk of cross contamination. Flooring in the sitting room was observed to be damaged. The kitchen was very small, but adequately equipped. The freezer drawers were broken and the light fixtures required cleaning.

The second apartment was well maintained, bright and clean. The bedrooms were spacious, there was a large bathroom and a large open plan kitchen, dining, and living area. There was a small garden area at the rear of the apartment, and the residents and staff have requested fencing to secure the area and afford more privacy, which the provider plans to install during the summer.

The inspector did not have the opportunity to observe a meal time experience. Residents main meals were supplied from a central kitchen. Residents chose their meals on a weekly basis, however there were alternative options and staff could also cook in the centre. The inspector observed a variety of food and drinks options. Residents were encouraged to be involved in the preparing and cooking of their meals, and the topics of healthy eating, home cooking, and shopping for groceries were discussed at recent resident meetings. The fridges, food storage presses, ovens, and microwaves were observed to be clean. Residents requiring support with food and drinks were assessed by speech and language therapists, and there were feeding, eating, drinking and swallow (FEDS) plan available as required.

The provider had established fire safety management systems. Both apartments were fitted with fire alarms, fire doors, extinguishers, fire blankets, and emergency lights. The fire alarms, extinguishers, blankets, and emergency lights were serviced on a scheduled basis, and staff were also completing daily fire safety checks, however, some gaps were found in the staff checks. While there was a detection and alarm system in place, the fire panels were located outside the building and did not alert staff to identify the exact location of fire, should it occur. The provider

however, had a comprehensive plan in place to upgrade the fire alarm and emergency lighting system.

The inspector checked several of the fire doors and found that they closed properly. One of the bedroom fire doors did not have a magnetic self-closing device. A storage press along the main corridor in one apartment contained a tumble dryer, however there was no fire door on the press. There was medical gas stored in one apartment. The storage of the gas had been risk assessed, although the risk assessment referred to another centre in parts, and was found to be safely stored with regular checks taking place. Regular fire drills took place in both apartments, including drills to test night time staffing levels. Fire evacuation plans and personal evacuation plans were available to guide staff in supporting residents to safely evacuate. The plans were up-to-date, however, the inspector found that some required revision to align information on the use of a wheelchair. One staff member spoken with advised the inspector on how residents were supported to evacuate during a recent drill and was aware of the procedures to be followed.

The provider had implemented measures to protect the residents from the risk of infection. Staff had access to written policies and procedures on infection prevention and control (IPC) matters, as well as public health information on COVID-19 and IPC. There was also accessible information for residents on COVID-19, vaccines, and testing. There was an IPC clinical nurse specialist, COVID-19 officer, and COVID-19 response team available to support the centre. The person in charge had completed risk assessment on IPC matters such as COVID-19 and other infectious diseases that identified corresponding control measures. The centre's COVID-19 contingency management plan required revision regarding updated management details. A COVID-19 self assessment tool had been completed, but undated to indicate when it was completed.

Staff members spoken with the inspector about some of the IPC measures. They spoke about their training on hand hygiene and on the use of personal protective equipment (PPE), however, one staff advised the inspector that they had not completed training on standard precautions. Staff also advised the inspector on the arrangements for managing soiled laundry and bodily fluid spills, and spoke about some of the COVID-19 precautions. COVID-19 and IPC was regularly discussed at team meetings to enhance staff knowledge of the related measures.

There was dedicated housekeeping staff working in the centre with responsibility for cleaning, staff providing care and support to residents also completed cleaning duties. Staff used colour coded cleaning equipment as a measure against cross contamination, and there was an adequate supply of cleaning equipment and chemicals. A mop bucket was observed stored at the back of one of the apartments which presented a risk to the cleanliness of the equipment. The washing machines were observed to be clean and had regular cleaning schedules. The inspector observed some gaps in the recording of the cleaning checklists which required enhancement, however overall the centre was clean. The inspector observed there to be sufficient hand washing facilities, including soap and sanitiser, paper towels, waste bins, and hot water in taps.

The quality team member advised the inspector on how residents were being supported to engage in activities. It had been identified that improvements were required to support residents to engage in social activities and work had commenced to on this, for example, residents' interests and preferences were assessed, staff were educated and up-skilled on providing a meaningful day, and the quality team were providing ongoing support and monitoring of the centre. Some staff spoken with, advised the inspector that the involvement of the quality team had been beneficial in promoting more community based activities.

The inspector found that the arrangements for the maintenance and accessibility of residents' personal plans was poor. The majority of residents' personal plans for their health, social and personal care needs were stored on the provider's electronic database system. The inspector sought to view of a sample of residents' plans from both apartments. The plans could not be located. Furthermore, some staff working in the centre advised the inspector that they had not seen or read care plans in relation to epilepsy or intimate care. The absence of personal plans posed a significant risk to the quality and safety of care provided to residents, as staff could not access guidance to inform their delivery of care interventions required by residents.

The person in charge had ensured that residents' health care needs were assessed, and the inspector found that the assessments were comprehensive and up-to-date. However, as described above, some healthcare plans were not available. Residents did have access to a wide range of multidisciplinary supports, including occupational therapy, dietitian, clinical nurse specialists, social workers, and speech and language therapists. Residents also had access to general practitioners, and nursing care was available at times within the centre. Some residents had also availed of national screening programmes.

Each resident had a communication plan, and they were available in hard copy for the inspector to view. The plans, dated 2020, were found to require updating as some of the information was very out of date, for example, details of their family members. One of the plans also referred to a communication support that the resident used, however, staff advised the inspector that the support was no longer used. There was Wi-Fi and electronic devices for residents to use as well as other media forms such as televisions and magazines.

Positive behaviour support plans were prepared for residents requiring support in this area. The plans viewed by the inspector had been recently reviewed, and were available to staff. Restrictive practices implemented in the centre including locked doors, an angel guard, chemical restraint, and a low level physical hold. There were protocols for the locked doors, angel guard and chemical restraint, and their use was recorded. However, not all recordings demonstrated that restrictions were used for the shortest duration necessary or that alternative options had been tried. There was no written protocol for the low level physical hold, which meant that staff were implementing a physical restraint without sufficient guidance or approval. Improvements were also required to demonstrate how residents or their representatives had consented and been involved in the decision to implement the

restraints.

The provider had implemented measures to safeguard and protect residents from abuse. The inspector found that safeguarding concerns were appropriately reported and screened, and safeguarding plans were developed as required. One safeguarding plan was found to require revision to reflect some of the current interventions. Safeguarding and adverse incidents were discussed and reviewed at team meetings for learning purposes. All staff in the centre had completed safeguarding training to support them to appropriately prevent, detect, and respond to safeguarding concerns. One staff member spoken with, told the inspector about the procedures to be followed in the event of a safeguarding concern.

Regulation 10: Communication

There were communication plans for residents outlining the supports they required, however the plans required review and updating as some of the information was found to be out of date, for example, supports used by residents, and information on family members.

The registered provider had ensured that residents had access to media sources, such as televisions, magazines, and the Internet. Some residents used electronic devices to keep in contact with their loved ones.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was generally well maintained and clean, however some upkeep and attention was required in one of the apartments. The centre was small in space and did not meet the needs of some of the residents 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 18: Food and nutrition

The residents main meals were supplied by a central campus based kitchen, however some meals were cooked within the centre. Residents chose their main meals on a weekly basis but there were alternative options for them to choose from.

The person in charge had ensured that residents were supported to buy, prepare and cook their own meals. Residents were encouraged to be involved in their meal planning, and the topics of health eating, home cooking and grocery shopping had been discussed at recent resident meetings. There was a good supply and variety of food and drinks available to residents in the centre. One of the residents advised the inspector that they liked the food in the centre. The cooking facilities and storage facilities were adequate and found to be clean.

Residents requiring support with food and drinks were assessed by speech and language therapists, and there were feeding, eating, drinking and swallow (FEDS) available outlining the supports required.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had adopted procedures to protect residents against infection. The procedures were underpinned by written policies and procedures on infection prevention and control matters, which were available to staff in soft and hard forms. Staff also had access to information from public health on COVID-19 and IPC. A COVID-19 contingency plan, dated November 2021, required some minor amendments. An undated COVID-19 self assessment tool had also been completed. The provider had good resources to support the centre with infection matters, including a COVID-19 officer, IPC nurse specialist, and COVID-19 committee. An IPC/hygiene audit had been carried out, which was comprehensive and identified actions for improvement.

There was easy-to-read information available for residents on IPC and COVID-19 to add their understanding of the associated measures and procedures.

Staff working in the centre were required to complete IPC training, and spoke to the inspector about the training and some of the measures implemented in the centre such as the management of soiled laundry and bodily fluid spills, and COVID-19 precautions. There was dedicated cleaning staff, but care staff were also involved in the cleaning of the centre. The centre was generally clean and there was a good supply of cleaning equipment and chemicals, including colour coded clothes as a measure against cross contamination. The inspector found some minor gaps in the cleaning records, which also required enhancement to include the shower chairs used by residents.

There was sufficient hand washing facilities and access to PPE. However, some practices required improvement for optimum IPC standards, for example, a mop bucket was observed stored outside, a light fixture required cleaning, the storage arrangements of toothbrushes in shared bathrooms presented a risk of cross contamination, and there were chipped tiles in a shower.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had implemented fire safety precautions and management systems. There was fire extinguishers, blankets, alarms, doors, and emergency lights in both apartments. The equipment had been serviced, and staff also completed fire safety checks. There were minor gaps in the staff fire safety checks. The inspector checked several of the fire doors and they all closed properly when released. Consideration of the need for a fire door on the storage press in the main hallway of one apartment is required.

While there was a detection and alarm system in place in centre, the fire panels were located outside the centre and did not alert staff to identify the exact location of fire, should it occur. The provider however, had a comprehensive plan in place to upgrade the fire alarm and emergency lighting system for all designated centres on the campus. This would result in each centre having a high standard fire alarm system and addressable fire panel installed in the centres on a phased basis.

Staff working in the centre completed fire safety training, and staff spoken with were able to describe the evacuation procedures to the inspector. There were regular fire drills, including drills reflective of night time staffing levels. Fire evacuation plans and individual personal evacuation plans had been prepared and were readily available in the centre. The inspector found that one of the plans required minor amendment in relation to equipment used by a resident.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Some of the residents' health, personal and social care plans requested by the inspector were not available, including the plans on epilepsy, skin care, constipation, falls, mental health, and intimate care.

The provider utilised an electronic database for maintaining most of the residents' personal plans. Staff in the centre had difficulty navigating the database, and the staff and person in charge could not retrieve the plans for the inspector to view. Some staff spoken with told the inspector, that they were not aware of some key health care plans, for example, epilepsy care plans. The absence of plans for staff to refer to posed a serious risk to the safety and quality of care to residents as it could not be demonstrated that care interventions were been appropriately implemented in accordance with residents' assessed needs.

Furthermore, it could not be demonstrated how the effectiveness of personal plans

was reviewed, or how residents or their representatives were involved in the development of their personal plans.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to healthcare services, including multidisciplinary services such as occupational therapy, speech and language therapy, clinical nurse specialists, and dietitians. Residents were seen by general practitioners, and nursing input was provided in the centre. Some residents had also availed of national screening programmes.

The person in charge had ensured that residents' healthcare needs were assessed. However, as the some of the residents' healthcare plans were not available to view, it could not be demonstrated that all of their healthcare needs were being met.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Restrictive practices including physical, chemical, and environmental restraints were implemented in the centre.

Use of some of the restrictions was recorded, however, some of the records did not adequately demonstrate that they had been implemented for the shortest duration necessary or that all alternative measures were considered before the restrictions were used. The involvement of residents or their representatives also required improvement to demonstrate that restrictions were being implemented with their informed consent.

There was no protocol for the use of a low level physical restraint used for one resident on a regular basis. The absence of a clear protocol to effectively guide staff posed a significant risk to the safe care of residents.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented systems to protect residents from abuse. The systems were underpinned by a comprehensive policy and associated

procedures. Staff working in the centre had completed safeguarding training to support them in preventing, detecting, and responding to safeguarding concerns; and staff spoken with were able to describe the procedure for responding to safeguarding concerns. The inspector found that safeguarding concerns were recorded, reported and screened, and safeguarding plans were developed as required. One safeguarding plan required some updating. Safeguarding concerns and incidents were also discussed at staff team meetings for review.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 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 10: Communication	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

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

Inspection ID: MON-0028363

Date of inspection: 21/06/2022

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**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The current staffing deficit in this Designated Centre is minus .36 WTE. A new social care worker is due to start in the coming weeks which will bring the Designated Centre to plus .64 WTE. The new social care worker staff will help with the skill mix in the DC and will also help to cover staffing deficits. The employment of this new staff will also help the current person in charge to strengthen the governance and management in the Designated Centre.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Additional training has been completed in this Designated Centre since this inspection. There was a meeting with the DOC and manager over education and training on the 15th of July regarding deficits in staff training for DC 29. This was then discussed with the DOC and PIC in relation to plans to address deficits. Specific training regarding positive behavior support training, epilepsy and FEDS training have been added to the training matrix for the Designated Centre. All staff training in Designated Centre 29 will be at 100% compliant by the 16th of September.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
With the employment of a new social care worker for the Designated Centre it will further strengthen the governance and management in the designated Centre. There had been 2 previous register provider audits completed in February and June this year. A further provider audit will be completed by the Quality office at the end of August 2022. Due to poor findings in 2020 and again in this report the DOC, PPIM, PIC and head of Quality will meet on a weekly basis to ensure actions are completed from all audits and the Designated Centre becomes compliant in all regulations.

The PIC has completed supervision and house meetings with staff and discussed the only restrictive practices agreed within the designated Centre.

The DOC has requested that the assistant director of nursing complete a full review on the personal plans in Designated Centre 29 with the current staff nurse and PIC. This will be completed throughout August 2022. The PIC and staff nurse will then complete individual sessions with staff to ensure they are fully aware and knowledgeable on all personal plans.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The DOC, PPIM and PIC had a meeting on the 15th of July and went through all required incidents that need to be reported.
A low level physical hold is no longer in place and all staff are fully aware of this through recent house meeting and through supervisions.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
All communication plans for all residents have been updated since this inspection.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The provider continues to engage with external stakeholder for suitable accommodation for the residents in Designated Centre 29.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: COVID-19 contingency plan has now been updated since this inspection. All staff will be trained in IPC training before the 16th of September. A further IPC audit will be carried out before the 31/07/2022 to ensure optimum IPC standards are followed Gaps in cleaning records have been addressed by the person in charge along with a full review of the cleaning schedule template with changes implemented.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A comprehensive plan is in place to upgrade the fire alarm and emergency lighting system for Designated Centre 29. This would result in Designated Centre having a high standard fire alarm system and addressable fire panel installed in each home. All personal fire evacuation plans have been reviewed by the person in charge since this inspection. All oustanding fire training will be complete by the 31st of August. A Fire door has been ordered on the storage press in the main hallway of one apartment	
Regulation 5: Individual assessment	Not Compliant

and personal plan	

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All residents in Designated Centre 29 have their personal plans and assessments available on the new electronic database since this inspection.
There has been ongoing support offered by the learning and development department regarding the usage of the electronical database with staff.
The DOC has requested that the assistant director of nursing complete a full review on the health care plans in Designated Centre 29 with the current staff nurse and PIC. This will be completed throughout August 2022. The PIC and staff nurse will then complete individual sessions with staff to ensure they are fully aware and knowledgeable on all health care plans.

Some MDT meetings for residents have been completed in 2022 with others scheduled in August 2022. At these meeting family representatives are invited along with the resident. At all MDTs a full review of the personal care plan is completed in consultation with the resident and family

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All health care plans have been updated and all residents' healthcare needs are being met. There are now soft copy and hard copy health care plans available in this Designated Centre.

The DOC has requested that the assistant director of nursing complete a full review on the health care plans in Designated Centre 29 with the current staff nurse and PIC. This will be completed throughout August 2022. The PIC and staff nurse will then complete individual sessions with staff to ensure they are fully aware and knowledgeable on all health care plans.
Some MDT meetings for residents have been completed in 2022 with others scheduled in August 2022. At these meeting family representatives are invited along with the resident. At all MDTs a full review of the health care plans are completed in consultation with the resident and family

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The positive behaviour plans for all residents were up to date for this inspection. One resident has two Positive Behaviour Plans in place, as one was developed specifically to support this resident with their personal care. Their positive behaviour plan in personal care is developed with proactive strategies and the trial of this is currently ongoing. The restrictive practices for locked internal door (bathroom door) and the low level MAPA hold were discontinued while the proactive strategies are being trailed. The positive behaviour plan is ongoing and the PBS specialist is supporting staff to implement the positive behaviour plan. A follow up multidisciplinary team meeting is being scheduled to seek the support from physiotherapy, occupational therapy and psychiatry with the ongoing implementation of the positive behaviour plan.

The DOC has requested that the restrictive practice committee develop protocols and documentation for informed consent around restrictive practices.

In Designated Centre 29 discussions have been held with family representatives and with residents in relation to current restrictions within their home.

There is a recording form in place in one apartment, stating the type of Restrictive Practice and the recording that the restriction is used for the shortest duration necessary. This is filled each day by the staff on duty.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	15/07/2022
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	15/09/2022
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	Not Compliant	Orange	31/08/2022

	statement of purpose and the size and layout of the designated centre.			
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.	Substantially Compliant	Yellow	31/07/2022
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	31/08/2022
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	16/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/08/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/12/2022

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/12/2022
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	31/08/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as	Substantially Compliant	Yellow	31/08/2022

	determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	31/08/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures	Substantially Compliant	Yellow	31/07/2022

	consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/08/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/08/2022
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Substantially Compliant	Yellow	30/11/2022
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2022

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	31/08/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/07/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/07/2022
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the	Not Compliant	Orange	31/07/2022

	resident's personal development in accordance with his or her wishes.			
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	31/08/2022
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Substantially Compliant	Yellow	31/07/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be	Substantially Compliant	Yellow	31/08/2022

	multidisciplinary.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	31/08/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Red	30/06/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	15/07/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is	Substantially Compliant	Yellow	15/07/2022

	made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	15/07/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	15/07/2022