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 16
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	30 March 2021
Centre ID:	OSV-0005859
Fieldwork ID:	MON-0028428

About the designated centre

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

This designated centre is intended to provide long stay residential care and support to no more than 10 men and women with complex support needs. The centre comprises two wheelchair accessible bungalows, located in a campus setting in Dublin 20. The designated centre is located close to local amenities, transport links and community facilities. The service aims to provide a comfortable safe home that promotes people's independence, and a high standard of care and support in accordance with evidence based practice. Residents' healthcare supports are provided by medical doctors and allied professionals are available to residents as required. Nursing support is provided within the centre. The centre is managed by a person in charge who is a clinical nurse manager and is staffed by nurses, care assistants and day services staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 30 March 2021	10:00hrs to 17:00hrs	Louise Renwick	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector did not spend extended periods of time with residents. However, the inspector briefly met seven of the ten residents who live in the designated centre during the inspection, and spoke specifically with one resident, being cognisant of public health guidelines; maintaining physical distance, wearing appropriate personal protective equipment (PPE) and engaging in frequent hand hygiene. The inspector also reviewed recent questionnaires from some residents and family members that had been completed during the last annual review and found that residents and families were satisfied with the services being offered.

The centre comprises two bungalows, located close to each other. The inspector visited one of the two bungalows in the designated centre during the inspection.

Residents were nicely dressed and appeared comfortable in their home. The inspector saw residents relaxing in the living room; some were watching television and some were listening to their headphones. Some residents told the inspector they liked to help with the laundry; folding it and putting it away.

Some residents communicated through alternative methods and staff were seen to be responsive to requests. For example, a resident indicated that they wished to change their clothes, and to have a cup of tea and were supported by staff to do so. Staff engagement with residents was respectful, positive and warm.

There was a nice atmosphere in the bungalow visited, and a resident showed the inspector their bedroom and the new television that was mounted on the wall. The inspector spent time in the back garden area speaking with a resident and staff member outside. The resident told the inspector they wished their garden was nicer as it wasn't usable the way that it was. They would like to sit outside on a nice day and felt that the other residents would really like that too. Staff also told the inspector that other residents would use the garden if it was accessible to them, but it was difficult due to the uneven ground and grass.

The premises in one of the bungalows were small for the number and needs of the six residents living there. Residents required mobility and comfort aids such as comfort chairs, wheelchairs and hoists. There was one living space which was open plan living and dining area, next to a small kitchen. Residents spent time either in their own bedrooms, or in this open-plan communal space. While the inspector saw that this room was nicely decorated and had photographs of residents throughout, it was limited in size for the number of residents and staff members on duty.

The inspector reviewed documents such as incident records and daily notes, and saw that meals took time, as each resident was supported with their individual needs, with most residents requiring one-to-one support. This proved a challenge for staff, if other residents required attention during their time supporting a safe and

positive meal time experience.

There was a bathroom in one of the bungalows and the bath had been recently removed. There was a wet shower room along with a stand alone toilet for residents' use also. At the time of the inspection, some residents in this home were no longer able to use the shower chair in the wet room due to their changing needs, and a shower trolley had been ordered by the person in charge. However, this was taking some time to arrive and since January 2021 some residents were not able to use the shower facilities in their home. At the time of report writing the person in charge informed the inspector that a replacement shower trolley had been put in place, until the new one was delivered, to ensure all residents could use the facilities.

Some residents told the inspector that they kept in contact with their family through telephone or video call, and they enjoyed meeting people on the campus for conversation.

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

Capacity and capability

The provider did not fully demonstrate they had the capacity and capability to operate the centre in a manner that ensured a good quality, safe service. The statement of purpose did not clearly set out the specific support needs and services that could be provided in the centre. Improvements were required to ensure effective oversight of staff practice and the management of staff resources to meet the changing needs of residents. In addition, there had been a period where the management structure for the centre was not stable resulting in ineffective oversight. The provider had also failed to take appropriate action to address actions identified through their own provider-led audits and reviews in a timely manner.

In the absence of a clearly defined Statement of Purpose that set out the specific care and support needs to be accommodated in the designated centre, the staff team were challenged with trying to meet varying support needs of residents. Without specifically identifying the care and support needs that the centre could facilitate, there was a lack of focus on key training areas for staff. The premises had also not been reviewed to ensure the changing needs of residents as they age could be accommodated safely.

The oversight of the care and support provided in the designated centre required improvement at senior and local management level. The governance and oversight

arrangements for the designated centre had been previously unstable, as the provider had not ensured a full-time person in charge was in place during a 12 month period and there had been changes to senior management personnel also. This had hampered the provider's ability to make necessary improvements.

While a full-time person in charge was appointed in August 2020, there was an absence of a formal operational oversight system for the person in charge to continuously review and audit key areas in relation to the care and support being delivered and in general, oversight of practice required improvement. For example, to ensure all risk control measures were implemented, to ensure staff training was attended and recorded and that any incidents were recorded and reported in the appropriate manner.

The provider had arranged for an annual review of the designated centre for 2020, which assessed the centre in line with the Standards. This annual review included the views of residents and relatives, and resulted in an action plan of recommendations. Feedback reviewed from residents and their representatives showed they were satisfied with the services being offered to them. The provider had also carried out unannounced visits to the designated centre which assessed the care support in line with the regulations. However, they were not inclusive of all parts of the centre on a six monthly basis.

While some issues identified through these audits had been acted upon, some areas of importance had not been resolved.

Staff were seen to be engaging respectfully and warmly with residents, through responding kindly to their requests and speaking of residents in a positive and professional manner. That being said, the number of staff on duty during the day-time and night-time required review and further assessment to ensure an adequate number of staff were available to support the varying needs of residents in the designated centre at all times.

In the absence of a requirement for a desired qualification for all staff members, the provider had not provided adequate training to the staff team in key areas of residents' care and support to enhance their abilities.

While mandatory training was identified through the provider's policies, the specific training requirements for the staff team of this designated centre had not been fully considered. For example, training in palliative care, end of life care and positive behaviour support had not been identified as required training, yet the staff team were supporting residents with these particular needs.

There was an improved system of formal supervision in place for the staff team since the previous inspection, along with pre-planned staff team meetings with the person in charge. Attendance at staff meetings was deemed to be mandatory, and while the frequency of meetings had improved since the last inspection, low numbers of staff attended or verified that they had read the meeting minutes. This did not ensure all staff were aware of items discussed, or actions to be addressed.

Overall, improvements were required to ensure a stable management structure was

maintained in the designated centre, and that effective systems of oversight were implemented to ensure a good quality and safe service was available to residents. Improvements were also required in relation to the specific care and support needs being supported in the centre and ensuring the staffing resources and premises available were fully suitable in meeting those needs.

Regulation 14: Persons in charge

There was a full-time person in charge appointed to work in the designated centre, who was suitably skilled, experienced and qualified. For example, the person in charge was a qualified nurse and held qualifications in management. The person in charge was responsible for one designated centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing in place at the time of the inspection, was not in line with the written statement of purpose. While the provider had reduced the numbers of staff in the premises as a measure to reduce footfall during the COVID-19 pandemic, the impact of this had not been fully considered. Previously some residents had been supported in a one-to-one capacity to promote safeguarding in the designated centre, however, this was no longer available. The staffing levels at day-time and night-time required review to ensure an adequate number of staff were available to support the varying needs of residents in the designated centre at all times.

Staff resources were not managed in line with residents' needs, but rather were managed based on the resources available and set staffing arrangements. For example, set shift patterns at day and night. Similarly at night-time, residents were often awake and required some support, however, staffing remained at one care assistant during the 8pm to 8am period in each unit of the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

While mandatory training was identified through the provider's policies, the provider had not identified the specific training requirements of the staff team in this designated centre, and made this training available to staff. For example, in palliative care, dementia care and positive behaviour support.

There were gaps in the training available for staff in relation to infection control practices. With evidence of only six staff having completed infection control training out of 21 staff identified, and 11 staff having completed hand hygiene training out of 21 staff identified.

Some mandatory training that had been provided to staff was in need of refreshing and updating. For example, manual handling.

Judgment: Not compliant

Regulation 23: Governance and management

While there were unannounced visits on behalf of the provider on a six-monthly basis, these visits did not include all units of the designated centre.

The management systems in place were not ensuring effective monitoring and oversight arrangements of the care and support being delivered. For example, in respect of the varying support needs in the designated centre, the compatibility of residents and incident management review.

The provider had not taken timely action to address any concerns raised through their own audits and reviews, inspections or compliance plans. For example, the increase of staffing to support safeguarding and the improvements required to the premises and garden area.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to ensure it reflected the recent changes to person in charge and persons participating in management.

The statement of purpose required review by the provider, to clarify the specific care and support needs that could be met within this centre. For example, the written document indicated the centre could support medium to high dependency but did not specific the other needs that could, or could not be supported to a good standard within the designated centre.

Judgment: Substantially compliant

Quality and safety

On this inspection while it was demonstrated that residents' health care needs were met, and residents were satisfied with their service, it was not demonstrated that all residents' needs were adequately assessed and considered in relation to the group of people living in the home, and the impact of the environment on residents' lived experience.

The designated centre was nicely decorated with soft furnishing and photographs of residents on display throughout the main rooms. While some residents' bedrooms were small, rooms were seen to be decorated in line with residents' choice and wishes, and some residents had televisions in their room. However, overall communal spaces were limited in one bungalow for the six residents living there, and the additional mobility and comfort aids they required for their care.

Since the inspection in July 2019, residents' needs in relation to their mobility and their supports had changed. Bedrooms for some residents were limited in the space available for manual handling equipment required. The main corridor to the bedrooms was narrow with only enough space for one person at a time, which made movement around the designated centre a challenge for the number of residents and staff in the building. Residents spent time either in their own bedrooms, or in the living/dining room, which was the only communal space available in this unit of the centre.

The garden area in one of the bungalows was not accessible for all residents. There was a small paved area at the front of the home, which was sloped and a large green space at the rear of the bungalow that was not fully accessible for residents to use. Some residents told the inspector they wished their garden could be used, as they would like to spend time in it, especially when the weather was nice and they were spending a lot of time at home over the past year.

In one unit of the designated centre, there were inadequate washing facilities for all residents' use, and additional equipment to support their personal care needs was not available. For example, some residents now required the use of a shower trolley to support them safely with personal care. While this had been ordered, it was not yet available which resulted in some residents not being able to access the showering facilities since January 2021. At the time of writing the report, a replacement shower trolley had been put in place, until the new equipment arrived. Overall, the premises of one of the bungalows were small for number and changing needs of residents along with mobility tools and devices needed to support them in their care. For example, hoists, comfort chairs and wheelchairs.

The second bungalow provided care and support for four residents. This building offered four individual bedrooms for residents, one of which had a large wet room en-suite. This bungalow also had a second living room for residents' use.

While residents expressed satisfaction living in the centre and appeared relaxed in each other's company on the day of inspection, in one bungalow not all residents' needs were compatible with each other, and this resulted in some peer to peer

incidents and behaviour that was challenging for the staff team to support.

The systems in place to identify, record and report incidents of a safeguarding nature were not adequate in the designated centre. This had been identified through the provider's own review of safeguarding in the designated centre which identified incidents were not consistently being recorded as safeguarding, nor screened in line with National Policy, as required. The person in charge and programme manager had created an action plan to rectify issues in incident recording and improve reporting in the designated centre.

Where safeguarding plans had been put in place, they had not been formalised and the provider had not ensured they were fully effective at managing the risk. This was identified as an issue in the provider's unannounced audit in May 2020.

While the impact of incidents were low and incidents were well managed by the staff team, they were repeated and there was an ongoing level of risk. This was indicative of the larger issue of compatibility of residents, the lack of a clearly defined statement of purpose outlining the needs that the centre could support and the number of staff available to support them.

Behaviour support assessments and plans did not always identify the underlying cause or function of problematic behaviour. Interventions to positively support residents were often dependent on one staff being available to engage in activity with a resident or to give attention. This had proved a challenge for the staff team, as behaviour of concern often occurred at times when staff members were fully engaged in the needs of other residents for example, at meal times or times of personal care. Behaviour support interventions did not consider the impact of the environment on residents' behaviour, nor whom they lived with. The compatibility of the residents in the designated centre had not been assessed or considered fully in respect of the impact this had on residents' behaviour.

The effects of the COVID-19 pandemic had heightened some of these issues and the opportunities for residents to engage in a wider variety of activities had been limited due to national restrictions. This had also impacted on some of the extended supports available for some residents for example, observations by allied health professionals for the purposes of assessment.

The provider had systems in place in relation to the management of the risk of infection and had implemented infection control practices within the centre. For example, records were maintained of cleaning checklists of high use areas, staff and residents had twice daily temperature checks and there were ample supplies of PPE (personal protective equipment). The inspector observed staff wearing surgical masks throughout their shift, with access to hand sanitiser and hand washing throughout the premises. Times of suspected infection had been well managed and protocols were followed effectively to reduce risks. However, some improvements were require to ensure risk assessments and documentation was specific to the centre and gave clear direction on contingency plans.

The inspector reviewed a sample of residents' assessments and plans which were maintained online. The inspector found that residents had annual medical reviews,

good access to their general practitioner (GP) and to other allied health professionals, as required. The provider had a clinical team available for residents consisting of occupational therapy, physiotherapy, speech and language services and psychology and behaviour support services. The inspector noted an improvement since the previous inspection of the monitoring of health risks and needs, and appropriate referral and follow up appointments for health issues identified or emerging. While a system of assessing and planning for residents' needs was in place, it did not fully explore all personal and social care needs of residents in a holistic manner, and some care planning documentation required further enhancement. Similarly, further development was required in relation to assessing residents' needs in the context of their home, and their future needs should they wish to transition to other types of services.

Overall, the inspector found that residents were comfortable in their home, supported by a consistent and warm staff team and their health care needs were well monitored and planned for. That being said, improvements were required to ensure the centre's facilities and supports could adequately cater for the individual and collective needs of all residents.

Regulation 17: Premises

The provider had not ensured one unit of the designated centre could fully meet the assessed needs of residents, with regard to the design and lay out and the communal space available.

The provider had not acted upon the requirement to make the garden area accessible for residents, as per their original plans.

Showering facilities and aids available did not adequately meet the needs of all residents.

Judgment: Not compliant

Regulation 27: Protection against infection

While the provider had written plans and control measures in place to manage the risk of COVID-19, the centre-specific assessments and plans required improvement.

For example, risk assessments for residents did not include any barriers to isolation and how this would be supported. Written plans did not specifically identify the contingencies for areas such as staffing reduction in this location.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk.

On the day of inspection there were identified faults in some fire doors on residents' bedrooms. Two of these fire doors did not close correctly, and other fire doors had faults that required repair. There was a risk that control measures to contain fire were not adequate to protect residents.

Staff had also not been properly trained in the use of evacuation aids for some residents. There was a risk of harm to residents and staff should staff use aids that they had not received training in the use of.

The provider's response provided assurance that the risk was adequately addressed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Some residents' needs had not been fully assessed or planned for. For example, end of life care.

While some specific needs had assessments and care planning in place, further exploration was required to ensure these included personal and social care needs also. For example, dementia care plans.

Further assessment of residents' health, personal, social care and environmental needs were required, to ensure this designated centre is suitable for the purposes of meetings the needs of each resident, inclusive of the compatibility of residents living together.

In relation to potential transitions, residents' needs had not been appropriately assessed to inform future decisions.

Judgment: Not compliant

Regulation 6: Health care

Residents had timely access to their General Practitioner and allied health care professionals, as required. Residents had yearly health checks and multidisciplinary team meetings to guide their care.

Nursing care was provided within the designated centre, with evidence of health care planning and assessment and the oversight of monitoring tools for health needs or risks.

Residents were referred to the appropriate medical professional, where required and supported to attend health appointments and follow up to appointments.

Judgment: Compliant

Regulation 7: Positive behavioural support

Assessments and plans did not fully identify and alleviate the cause of a resident's behaviour of concern. For example, to identify all triggers or function of behaviour or to assess the impact of the environment or other residents.

Staff had not been supported to develop the skills and knowledge to respond to behaviour of concern and support residents with their needs.

Judgment: Substantially compliant

Regulation 8: Protection

Incidents of a safeguarding concern were not recorded and reported in line with National Policy for safeguarding Vulnerable adults. Potential safeguarding incidents had been recorded as "behavioural incidents" and had not been screened in line with National Policy for safeguarding vulnerable adults. For example, there were seven incidents where a resident had been pushed by a peer, this had not been noted as a safeguarding incident. The oversight of recording and reporting incidents required improvement to ensure any gaps in following process were quickly identified, and not reliant on an external audit to capture.

Of the incidents that were screened in line with national policy, safeguarding plans had been drafted but not all plans had been formalised. This had been identified as an issue in the provider's unannounced audit in May 2020 also.

The provider had not ensured that control measures fully promoted safeguarding. The control measures for ensuring residents' safety was dependent on staff supervision and redirection of persons causing harm. However, this was challenging due to the high dependency needs of some residents, and even at times of increased supervision, safeguarding incidents could occur. The provider's

unannounced visit report in May 2020 identified that one more staff was required to support and maintain good safeguarding practices in the designated centre. However, this had not been consistently put in place.
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	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 16 OSV-0005859

Inspection ID: MON-0028428

Date of inspection: 30/03/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Day service staff commenced in DC16 Bungalow 4 on 16.04.2021, working Monday to Friday 9 to 5pm, in line with current dependancy needs assessment. 2. Meeting scheduled with Human Resources Manager, Programme Manager and Person in Charge for full review of staffing levels on 27-05-2021 3. Person in charge shall submit business case for increased staffing due to changing health needs of service users and safety 28-05-2021	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Area specific training requirements to be reviewed by PIC and Learning and Development department to ensure all area specific training requirements are met for the needs of service users including Palliative and Dementia care training and Positive Behavior onsite training. 2. All staff on duty to complete infection control training by 31.07.2021 3. Monthly training audit compiled by HR department and sent to Person in Charge for review. 4. Fire training (for specific use of Ski Sheet and Ski Pad) scheduled for 31st May, 1st and 4th June. More dates to follow. Staff to complete specific fire equipment training 31.08.2021. 5. Person in charge will update and display traffic light training matrix on a quarterly bases in line with staff supervisions.	

6. Person in charge will address training at monthly house meeting and staff supervisions.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. 6 monthly scheduled reviews will continue as part of planned 2021 provider audits. 2. The Person In Charge and Programme Manager will be responsible to ensure the action plans from Register Provider audit are completed. 3. A standardized auditing system will be put in place for the Person In Charge and to complete to ensure consistent review of key quality indicators by 31/08/2021

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: 1. Update to current Statement of Purpose reflecting changes to Person in Charge and PPIM to be carried out. 2. Register Provider to carry of full review of current Statement of Purpose for Designated Centre 16. Updated SOP will give specific clarification about care and support needs that the centre can facilitate. This document will guide staffing type requirements, recommended qualifications and training needs for the area. Review will identify the provision of care based on the specific care and support needs that can be met within this DC by 31/08/2021

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: 1. Shower Trolley provided on 16.04.2021 to meet the needs of all service users. 2. Funding for Tracking system for one service users bedroom has been approved. Installation was due to be completed on 10/5/2021 but had to be postponed as house

was in precautionary isolation. To be completed before 31.05.2021. 3. Work has commenced on accessible garden on 07.05.2021 due to be completed 26.05.2021. 4. Additional 2nd shower / wet room allocated to contractor awaiting installation 31.12.2021. 5. Following transition of resident before 31/7/2021, bedroom will be converted to second living area – sensory or music room. This will be carried out before 31/12/2021.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: 1. Individual risk assessments have been reviewed and updated to identify possible barrier for service users to isolate. 2. Programme Manager and Person in charge identified emergency resource team with previous experience in DC 16 who could be used in the emergency event of staffing reduction 16.04.2021 3. Staff contingencies plan reviewed in the event of reduction in staff members respite and day service will close and staff reallocated to designated centre of identified staff and Designated 16

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 1. Faults on fire doors were repaired before the end of day on 30/03/2021 as an immediate action. 2. Training in the use of evacuation aids has been sourced externally. Training is scheduled for DC 16 staff on 31/5/2021, 1/6/2021, 4/6/2021. Further dates to follow to ensure all staff receive this training.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. Person in charge has liaised with Clinical Nurse Specialist developing person centered dementia health care plans 05.05.2021. 2. End of life care plans to be developed to reflect service user life stage, needs and wishes by 30.06.2021 3. The PIC will carry out a comprehensive review of all the personal plans to reflect the current support arrangements for residents by 31.08.2021 4. Audits of health care plans will be addressed at supervision with key nurse and / or key worker. Standardised audit tools to be provided by Registered Provider to all PIC's 30/06/2021. 5. Person in charge has completed 5 personal support plans audits to date. 5 personal support plans to be audited and discussed with key worker at supervision. 31.08.2021. 6. Person in charge updated transition plan to be reflective of service user strength, wishes and needs 04.04.2021.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: 1. Follow up MDT review scheduled for service user with ongoing behaviours of concern to identify any triggers or functional assessment of behavior on 31/5/2021. 2. Behaviour Support Person will provide area specific training before 30/06/2021 – working closely with staff who will transition with this service user to new home. 3. Transition plan in place and work has commenced on gradual transition to new home on campus. For completion before 31/07/2021.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. The Person in Charge has liaised with Safeguarding team and agreed plan for increased training and support for staff in DC report writing training, behaviour recording and safeguarding awareness. Date to be finalized. 2. All staff to complete online HSE Safeguarding training by 31.08.2021 3. Person in charge to review all behavioural incidents and complete mandatory reporting if an incident is of a safeguarding nature.	

4. Person in charge will discuss safeguarding at all monthly meetings and discuss at each staff quarterly supervision.
5. Formal safe guarding plan to be completed by Person In Charge by 17.05.2021.
6. Additional day activation staff in situ since 16.04.2021. Full staffing review by PIC, HR department and Programme Manager with follow up business case to be submitted by 28.05.2021

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	28/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/08/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/12/2021

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Not Compliant	Orange	31/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	26/05/2021
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	31/08/2021

Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/12/2021
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	13/05/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Red	02/04/2021

	maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Red	02/04/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/08/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently	Not Compliant	Orange	31/08/2021

	than on an annual basis.			
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).	Substantially Compliant	Yellow	31/12/2021
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	31/08/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/06/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is	Substantially Compliant	Yellow	30/06/2021

	made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	13/05/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	13/05/2021