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 24
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	14 March 2022
Centre ID:	OSV-0005836
Fieldwork ID:	MON-0027676

About the designated centre

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

Designated Centre 24 is a designated centre operated by Stewarts Care Ltd. The centre provides full-time residential support for no more than four women and men with intellectual disabilities and associated complex behaviour support and mental health needs who require bespoke single occupancy living arrangements. Designated Centre 24 comprises four separate single occupancy living areas, which are located on the ground floor within a larger building in a congregated campus based setting. Residents have access to a range allied health professional services as part of their ongoing assessment of needs and support requirements. Residents are supported by a staff team of a person in charge and care staff.

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
Monday 14 March 2022	09:45hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

This report outlines the finding of an announced inspection of this designated centre. This inspection was carried out to assess compliance with the regulations following the provider's application to renew registration of this designated centre.

The inspector ensured physical distancing measures were implemented as much as possible with residents and staff during the course of the inspection and also wore personal protective equipment (PPE).

During the inspection, the inspector met briefly with all residents present in the centre on the day of inspection.

One resident chose to spend a short time with the inspector and engaged in a brief chat. They mentioned they wanted to go back to live in the home they previously lived in however, later in the conversation they mentioned that they were happy living in this centre. They mentioned their favourite thing to do was to go out for coffee and they liked shopping. They mentioned they went down to the local village and bought magazines sometimes. They said the staff were nice to them and they brought them out to go shopping and get coffee. The resident said staff helped them when they needed help but sometimes they were tired and didn't always feel like walking to places.

The inspector asked the resident if they could look at their home, the resident said they were okay with that. Overall, it was demonstrated the residents living area was pleasantly decorated and bright throughout. There were aspects of the premises that demonstrated a somewhat institutional aesthetic due to the overall design of the building and structure of the premises. For example, the presence of large windows along the hallway and numerous observable pipes on walls.

The resident's bathroom was a large space that comprised a toilet and a shower cubicle placed in the centre of one end of the large tiled area. It was not clear why the shower cubicle had been placed in the room and aesthetically looked institutional.

Cleaning items and equipment were stored in the shower/toilet area which made the space look cluttered and impacted on the private bathing area space which was for use by the resident but was also being used to store cleaning products used by staff. This required review and improvement by the provider as the space was being used for a number of different functions with the needs of the resident not considered fully in terms of providing a homely environment, for example.

The inspector met briefly with the remaining three residents. Those residents didn't wish to engage in any specific conversation with the inspector and this choice was respected.

In the second living area, one resident was observed getting ready to go out on an activity with staff. They smiled at the inspector and waited at the exit door while the inspector engaged in a brief chat with them and staff. The inspector observed a large suite of refurbishment work was underway in this living area. The flooring was being replaced, a fire door was being fitted, the resident had received a new waterproof mattress and repainting was occurring throughout the space. The inspector observed the kitchen area required upgrade and modernisation, for example the kitchen cabinets were very worn and required replacing. The inspector also observed a significant collection of mould build up on the ceiling of the utility area of the living space.

The inspector spoke with a maintenance worker during the course of the inspection to ascertain what premises improvement works were going to occur to address the mould. This issue had been identified in the provider's scope of improvement works in the centre with the area due to be treated and improved air ventilation measures put in place to mitigate the build up of condensation in the area.

While this would suitably address the issue, it remained an infection control risk and required comprehensive action by the provider to treat it and ensure the premises upgrade measures would suitably mitigate it from occurring again. A finding in relation to this is identified under Regulation 27: Prevention of Infection.

In the third living area, the inspector observed another resident seated at the dining area where staff were providing them with a snack. They greeted the inspector but didn't wish to engage in a conversation. They were observed using their electronic device to watch and listen to videos of their choosing. The inspector asked for permission to observe their home and the resident nodded.

In this living space, the inspector observed it had been nicely decorated and laid out to meet the resident's needs. There were some areas of the living space that required refurbishment, for example, a number of areas in the living space required repainting, door frames and skirting was scuffed and the flooring in some areas need replacement due to wear and tear and noticeable marks.

The inspector visited the fourth living area. The resident living in there was spending time in their bedroom area, the inspector asked the resident if it was okay to enter their bedroom space and they said yes. The resident greeted the inspector briefly and then returned to looking out their bedroom window.

Overall, the inspector noted this living area was not decorated in as homely and pleasant aesthetic as the previous living spaces visited. It was also notable in this living space that staff were not actively engaging with the resident unlike in the other areas visited. In this living space again, the inspector observed there were refurbishments also required to enhance and upgrade the space. For example, new flooring and repainting was required throughout.

During the walk around of the designated centre, the inspector noted overall that the provider was putting arrangements in place to enhance the living spaces for residents to make them more homely and better maintained and this was observed during the course of the inspection with the inspector observing maintenance

workers laying new flooring and painting in one living area. However, overall there was an institutional aesthetic to the designated centre which would continue to pose the provider a challenge to continuously improve upon.

The inspector also observed the fire panel for the building was located in a room in one of the living areas visited during the course of the inspection. The recently appointed person in charge informed the inspector that the room was identified to be changed into a sensory space for the resident that lived in the space. It was not clear however, if the panel was to be removed and relocated to a different location for staff to use. When discussed with staff they informed the inspector that they did not use the fire panel as part of their fire evacuation procedures or as part of drills.

While the inspector was aware that the provider had plans to upgrade the fire safety systems throughout the campus, given that this designated centre was located within a larger building, the provider was required to review these matters as a priority to ensure there were appropriate fire safety alert and system supports for staff to be able to locate the source of fire and smoke and evacuate residents through a route away from the potential source of risk.

In summary, residents living in this designated centre were experiencing good care with some areas that required improvement in relation to the premises, infection control and some aspects of the fire safety systems.

The provider was also required to review and enhance the skill-mix and staff training in the centre to ensure residents' complex needs were met by staff suitably trained and skilled to meet not only their healthcare and supervision needs, but also with skills to support residents' social care needs to develop their potential and skills.

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 to each resident living in the centre.

Capacity and capability

The purpose of the inspection was to inform the registration renewal of the designated centre. The inspector found the provider was operating and managing this centre in a manner that ensured residents' needs were met by a staff team who were delivering a relatively safe service Improvements to the overall staffing skill-mix and staff supervision arrangements would ensure a better quality service for the needs of residents.

In addition, it was not clearly demonstrated, in the provider's statement of purpose, the type of service provision and assessed needs this centre provided for. The service description required more refinement and accuracy in it's description to

direct the types of staffing resources and supervision arrangements for the centre.

There had been a change of person in charge since the previous inspection. The provider had submitted a registration notification to the Chief Inspector of this change. All required information for this notification had been submitted as required. A full and complete application to renew registration had also been submitted. Some revision to the statement of purpose, as outlined, was required.

The person in charge reported to a programme manager who in turn reported to the director of care. The person in charge was knowledgeable of the needs of residents. They were responsible for this designated centre and another designated centre located nearby on the congregated campus. It was found that they had the appropriate qualifications to meet the requirements of Regulation 14.

Some improvement was required to the overall day-to-day management arrangements for the centre. The senior services manager was responsible for the centre in the absence of the person in charge. While this was a suitable arrangement for ensuring governance of the centre, there was no supervisor or manager assigned to the centre for managing the day-to-day operational management in the person in charge's absence. This was required given the configuration of the centre, the complex needs of residents and the lone working staff arrangements.

An annual review had been completed for 2021 by the provider. This review met the requirements of Regulation 23. The inspector noted the annual report was very comprehensive in scope, examined the provider's compliance against the disability standards and regulations, sought resident and family feedback and provided a scope of recommendations to improve the service for the next year.

The provider had also completed the required six-monthly provider led audits for the centre. These audits were comprehensive in scope and provided an improvement action plan to bring about enhanced compliance. In addition to these audits, the provider had also ensured additional auditing of the quality and safety of the service was carried out by other key provider stakeholders. Relevant appropriately qualified stakeholders had carried out audit reviews of risk management and infection control in the centre.

This demonstrated the provider had enhanced their governance and oversight arrangements for the centre and within their organisation and ensured they were well informed of the risks presenting in their designated centres and the actions needed to bring about an improved quality service.

While this was a positive initiative by the provider, there was an overall requirement for review of how records were managed in the centre. While there had been a comprehensive suite of audits and reviews carried out, they had been implemented for each of the four residential living areas and and were maintained in four separate documents rather than one overarching document or file. For example, the inspector noted there had been four separate six-monthly provider led audits carried out in the centre at the same time, there were four risk registers and four fire safety

folders.

Overall, this led to a confusing duplication of records maintained in the centre which were difficult to navigate in order to ascertain and identify the key issues that needed addressing for the centre and ensure issues were not missed if one document was not reviewed but others were.

Staff were provided with a schedule of training in mandatory areas such as safeguarding vulnerable adults, manual handling, fire safety and management of potential and actual aggression. However, improvements were required. The inspector noted there were gaps in refresher training across all mandatory training. In addition, there were gaps where some staff had not yet received mandatory training in the areas of fire safety and safeguarding vulnerable adults. While these were small gaps, this had a negative impact given staff worked in a generally lone-working capacity and required considerable improvement.

The inspector reviewed staffing arrangements for the centre. A planned and actual roster was maintained which identified staff names, their job role and hours planned and actually worked.

The provider had identified one WTE nurse staff was required for the centre, however, at the time of the inspection this post was vacant.

While there were a suitable number of staff working in the centre to meet residents supervision needs, improvements were required. For example, the skill mix for the centre, at the time of inspection, consisted of the person in charge and 21.3 WTE care staff. Residents living in the centre presented with complex mental health, medical and behaviour support needs which required consistent support and intervention.

It was not demonstrated that the staffing arrangements had been suitably resourced in such a manner so as to meet the assessed complex needs of residents. Coupled with the gaps in staff training in mandatory areas, considerable improvements were required with regards to staffing skill-mix resource arrangements, staff supervision, development and training for this designated centre

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a full and complete application to renew registration.

All required information to support the renewal application had been received and was found to be in line with the regulatory criteria as set out by the Chief Inspector.

Judgment: Compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The person in charge for the centre had changed following the provider's initial application to renew registration. The provider submitted a notification, as required to inform the Chief Inspector of this change of stakeholder.

All required information for this notification was received.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked in a full-time role and were responsible for this designated centre and another designated centre located also within the congregated campus.

Given the not compliant findings found on this inspection, the chief inspector was not satisfied that the provider had assigned the person in charge with a management remit that could ensure the effective governance, operational management and administration of the designated centres .

The person in charge had the required management experience and qualifications to meet the requirements of the role.

Judgment: Substantially compliant

Regulation 15: Staffing

The provider had ensured the staffing arrangements for the centre met the whole-time-equivalent numbers as per the statement of purpose for the most part, however, improvements were required.

The provider had identified one WTE nurse staff was required for the centre, however, at the time of the inspection this post was vacant.

While there were a suitable number of staff working in the centre to meet residents supervision needs, improvements were required.

For example, the skill mix for the centre, at the time of inspection, consisted of the

person in charge and 21.3 WTE care staff. Residents living in the centre presented with complex mental health, medical and behaviour support needs which required consistent support and intervention.

It was not demonstrated that the staffing arrangements had been suitably resourced in such a manner so as to meet the assessed complex needs of residents. This required improvement.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were provided with access to suitable training such as fire safety, safeguarding vulnerable adults, manual handling, management of potential and actual aggression, and infection control. Refresher training arrangements were also in place and it was demonstrated staff had been supported to receive refresher training in these areas.

However, there were improvements required as it was not demonstrated that all staff had completed mandatory training in key areas.

For example,

- One staff had not completed training in safeguarding vulnerable adults.
- Not all staff had completed training in management of actual or potential aggression.
- One staff required fire safety training.
- One staff required fire safety refresher training.
- One staff required refresher training in manual handling.

The provider had undertaken to enhance the skills of staff working in the centre by introducing training in the administration of medication and also administration of emergency rescue medication for the management of seizures. This initiative worked towards ensuring there were enhanced first response measures in the centre for residents during the day and at night time. This skills improvement initiative was ongoing at the time of inspection.

While this was a good initiative only four staff had taken up this training. Given that there was a nurse vacancy in the centre it was not demonstrated how the provider was ensuring staff were suitably skilled to meet the assessed needs of residents in a consistent manner in relation to medication management.

The provider had a staff supervision system in place. The recently appointed person in charge had begun implementing a formal supervision programme with staff and documented records were maintained in this regard. However, improvement was required.

It was not demonstrated that there were suitable arrangements in place to ensure

staff practice was appropriately supervised in the centre. Given that staff worked mostly in a one-to-one capacity with residents in separate areas within the designated centre and the person in charge was responsible for this designated centre and another on the campus which impacted on the their ability to provide direct supervision of staff practice to ensure good quality care.

Judgment: Not compliant

Regulation 21: Records

Copies of fire servicing records were not maintained in the designated centre and were maintained in a location off site.

Staff responsible for maintaining fire safety records for the designated centre told the inspector that they did not review these records or have knowledge of the outcome of the servicing checks.

This arrangement was not in compliance with the matters of Schedule 4 of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had completed an annual report for the previous year that met the requirements of Regulation 23.

The provider had completed required six-monthly provider-led audits for the centre. These audits were comprehensive and provided an action plan to improve compliance in the centre.

A full suite of documentation was maintained for each of the four single occupancy living areas that made up the centre. This led to a large number of duplicate folders and documents which presented as confusing and did not support the person in charge, provider or staff in having a comprehensive oversight of the designated centre risks and areas for quality improvement as a whole.

For example:

- A separate six-monthly provider-led audit had been carried out in each of the four living areas that comprised the centre. While this showed the provider's attempt to implement comprehensive oversight; there were a number of duplicate findings across each of the four audits completed and this led to a somewhat confusing overview and identification of areas that required

improvement in the centre as a whole.

- The provider had also instated additional quality oversight auditing in the centre by ensuring audits and quality reviews were carried out by key qualified provider stakeholders in specific areas. For example, quality and risk audits had been completed in the area of infection control, risk management and fire safety. Again, these audits had been carried out separately in each of the four living areas and did not provide an overarching systematic breakdown of the centre as a whole.

The provider had appointed a full-time person in charge for the centre that met the requirements of Regulation 14. The person in charge was also responsible for another designated centre located nearby on the congregated campus setting.

The senior services manager was responsible for the centre in the absence of the person in charge. While this was a suitable arrangement for ensuring governance of the centre, there was no supervisor or manager assigned to the centre for managing the day-to-day operational management of the centre in the person in charge's absence.

This was required given the configuration of the centre, the complex needs of residents and the lone working staffing arrangements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained the requirements of Schedule 1 of the regulations.

Some improvements were required to ensure the provider accurately described the specific support needs the centre intended to be met.

The statement of purpose outlined that the centre could provide long stay residential support for up to four men and women with high support needs.

However, this statement was generic in scope and did not provide an accurate enough description of the intended support and service arrangements provided in the centre.

For example, it did not set out if the support provided was for people with intellectual disabilities and further expansion on the term 'high support needs' was required.

This was to ensure the intended purpose and function of the centre was clearly set out, ensured the skill-mix and number of staff were suited to meet the intended purpose and needs of residents and to inform the admissions process for the centre.

Judgment: Substantially compliant

Quality and safety

This inspection found that residents were in receipt of a reasonable level of quality service, for the most part, that was meeting their supervision and support needs. However, improvements were required in the areas of fire safety, infection control, risk management and positive behaviour support.

The inspector reviewed infection control management in the centre and noted good contingency planning was in place. Alcohol hand gels were maintained at key areas, resident and staff temperature checks were taken and recorded daily. Daily cleaning checklists were maintained and updated each day. Personal protective equipment (PPE) was available for staff and staff were observed wearing face coverings during the course of the inspection which were in line with recent changes to public health guidance.

The provider had ensured a comprehensive infection control audit had been completed by a clinical nurse specialist in Infection Control with a separate audit for each residential living area having been completed. This audit had not only reviewed matters relating to COVID-19 but had also reviewed other areas related to standard infection control precautions. The audit had recently been carried out and had identified a number of areas related to aspects of the premises that were impacting on the infection control standards in the centre. However, some improvements were required.

There were aspects of the premises throughout that required refurbishment to ensure all areas were kept to a good standard to ensure adequate cleaning. Staff working in the centre engaged in the cleaning duties. However, it was not demonstrated that staff had received training in standard precautions and infection control, as set out in the provider's infection control policy. This was to ensure staff were suitably knowledgeable on standard control measures and could implement good practice while performing cleaning duties in the centre.

The inspector also observed a large collection of mould on the ceiling of the utility room space in one living area. While the provider had plans in place to address this issue, at the time of inspection, the mould was present, covered a large section of the ceiling in the room and posed a potential risk of infection.

There was evidence to demonstrate the provider's risk management policies and procedures were implemented in the centre. A risk register was maintained for each residential living area and recorded risks presenting and control measures in place to manage and mitigate risks identified.

Some improvement was required. It was not clear how trending and analysis of incidents were informing risk assessments in the centre. In addition, there was no

overarching risk register for the centre that captured all risks in one composite record for the purposes of governance and oversight monitoring.

It was observed that the provider had endeavoured to provide residents with a homely environment which, for the most part. Residents' bedrooms were nicely decorated and personalised. Residents living spaces, although spacious required refurbishment across all four settings. At the time of inspection one of the four living areas was undergoing refurbishment and the inspector observed maintenance workers installing new flooring and painting. The provider also submitted to the inspector, a suite of premises improvement project works that were due to be completed across all four living areas that comprised the centre. This would ensure that the premises was maintained to a better standard and would encompass some improvement in fire containment measures also.

It was noted however, that there were a high number of maintenance requests, logged by staff in 2021, that had not yet been addressed. System improvements were required to ensure minor maintenance request logs were followed up and addressed in a timely manner for the continuous upkeep of the premises.

There was a schedule of maintenance in place for fire safety equipment. However, copies of servicing records for fire safety equipment was not maintained in the centre. Therefore, the local staff team, the nominated fire warden staff member for the centre or person in charge were not aware of the outcome of servicing checks as part of the ongoing fire safety monitoring of the centre.

This was not in line with the requirements of Schedule 4 of the regulations where copies of fire servicing records must be maintained in the designated centre. The inspector requested copies of the servicing checks for the centre and these were provided shortly after the inspection. It was demonstrated that all fire equipment servicing records were up-to-date.

Staff had received training in fire safety management with refresher training available and provided as required. There were some staff that required refresher training and one staff required fire safety training.

Containment measures were in place in the centre and overall were to a good standard. Fire doors that were in place were fitted with door closers and smoke seals. The provider was also carrying out a process of installing additional fire containment doors in other areas and carrying out repairs to other doors within the centre.

Recorded fire drills had been carried out during and were maintained in the fire register for the centre. Each resident had a documented personal evacuation plan which was in date and maintained in the fire folder.

While there was a fire panel for the building, it was located in a room within one living area of the centre and not accessible to staff working in other areas of the premises.

The provider had not installed repeater panels located in each living area that made

up the designated centre to provide staff with information about the location of the fire so they could evacuate residents away from the source. Staff spoken with said they did not use fire panel for the purposes of fire drills or locating the source of smoke or fire and carried out an immediate evacuation with residents on the sounding of the alarm.

The inspector noted three of the four resident bedrooms in the centre had exit doors leading directly from their bedrooms which supported quick evacuation procedures for residents at night time and was the primary route for evacuation and practiced in drills. However, the evacuation route for one resident living area required review as they did not have an exit door leading from their bedroom. Staff showed the inspector the route they practiced during a drill which was to walk the hallway, through a containment door and then into the living room space and through an exit route that way.

The inspector was not assured that this route had been adequately reviewed as it meant there were a number of containment doors being opened as part of the evacuation process. The other potential route of evacuation, as outlined by staff, was through the main building.

The provider was required to review the personal evacuation route plan for the resident to ensure it was the safest and most efficient route for the resident to evacuate without impacting on the overall containment measures in the centre. This was of particular importance given the absence of an addressable fire panel to inform staff of the location of fire and smoke within the overall building.

The inspector reviewed the day and night time evacuation procedures for the centre. These required review to ensure they provided clear and accurate direction to staff on the evacuation routes for each resident within each individual living area. It was not demonstrated that the evacuation procedures provided enough detail to inform staff of what evacuation route each resident was to use during the day and night.

While there were a number of exit routes leading from resident living areas in the centre not all were fitted with an easy open mechanism, such as a thumb turn device. Keys were provided for opening of these doors and were maintained in a container near the doors. However, the inspector observed that the key holders were not easily opened and required staff to manually move a selection of numbered dials to enter a code before they could be opened.

This required review and improvement as it was not a suitable option and could impact on the timeliness of opening doors in the centre. The inspector observed the person in charge had difficulty opening one of the coded boxes to retrieve an exit door key, during the course of the inspection, this further compounded the evidence that this system was not the most effective arrangement.

The provider however, had a comprehensive plan in place to upgrade the fire alarm and emergency lighting system for all designated centres on the congregated 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. A copy of this

plan was submitted to the Chief Inspector following the inspection by way of demonstrating an assurance to HIQA that the provider had plans in place to improve fire safety measures in their centres to the most optimum standard.

As this centre was contained within a larger building, the provider was required to ensure they prioritised the fire safety improvements with regards to the fire alarm for this centre.

As discussed, residents living in this centre required positive behaviour supports and interventions and reviews of their mental health needs. Staff working in the centre had received training in breakaway techniques, however there were some gaps in this training. In addition, the inspector noted staff had not received training in positive behaviour support which would provide them with knowledge and understanding of how to implement behaviour support interventions in response to behaviours presented by residents from time-to-time.

Overall, there were a low level of restrictive practices, some residents were prescribed medications for the purposes of managing their behaviour support needs which were aligned to their mental health diagnosis and needs.

Some improvement was required to ensure more specific criteria was outlined in residents PRN administration protocols to ensure the criteria for administration was unambiguous and clear.

Regulation 17: Premises

Overall, the premises was maintained to a reasonable standard across all four living areas.

The general cleanliness of the centre was adequate and the provider had made arrangements to decorate the centre to make it as homely as possible. Some living areas were decorated and refurbished in a more homely manner than others.

It was however, noted that there was an overall institutional aesthetic to the premises which would require ongoing review and improvement by the provider to ensure residents were provided with the mostly homely environment possible.

In each of the four living areas residents' were provided with single occupancy large private bedrooms, a separate kitchen area, a large dining room/living room space with seating options. One resident was due to receive a sensory space in their living area.

However, improvements were required to ensure residents were provided with the most optimum home environment to meet their needs.

- Some areas of the centre required re-painting or touch ups to manage general wear and tear.

- Skirting boards and doors were scuffed in some areas.
- A large shower/toilet in one living area consisted of a stand-alone shower cubicle located within the larger tiled space. The room did not look aesthetically pleasing, provided a confusing configuration of the space and did not provide long-term plan arrangements should residents' mobility decline and be unable to enter the cubicle or require assistance when showering, for example.
- Some cracked tiles were observed in areas within the centre.
- One living area was not decorated in as homely style as other living areas.
- While residents' bedroom spaces were very large it was not demonstrated that these areas had been styled and furnished to maximise the space they provided and looked somewhat sparse and institutional as a result.
- Flooring in a number of areas required replacement.
- Kitchen cabinet units in one living area required replacement.

There were premises improvements required across all four living areas and the provider had identified as suite of premises improvement works, some of which were ongoing at the time of the inspection, therefore the regulatory judgment for this regulation was met with substantial compliance on this inspection.

While the provider had put in place systems to support the logging of maintenance requests it was not demonstrated that these logged requests were addressed in a timely manner with some requests having been logged the previous year but not yet addressed. This required improvement.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There was evidence to demonstrate the provider's risk management policies and procedures were implemented in the centre.

A risk register was maintained and recorded risks presenting in the centre and control measures in place to manage and mitigate these risks.

Some improvement was required. It was not clear how trending and analysis of incidents were informing risk assessments in the centre.

Also, there was no overarching risk register for the centre as each living area had a separate risk register in place which did not provide good capture of centre based of the designated centre as a whole.

A control measure to prevent risk of burns from radiators had not been addressed in a timely manner. While a request to install a radiator cover had been logged in a maintenance request, as part of a risk control measure, this had not been addressed at the time of inspection.

Judgment: Substantially compliant

Regulation 27: Protection against infection

It was noted good COVID-19 outbreak contingency planning planning was in place.

Alcohol hand gels were maintained at key areas, resident and staff temperature checks were taken and recorded daily. Daily cleaning checklists were maintained and updated.

Personal protective equipment (PPE) was available for staff and staff were observed wearing face coverings during the course of the inspection which were in line with recent changes to public health guidance.

The provider had ensured a comprehensive infection control audit had been completed by a clinical nurse specialist in Infection Control for each living area that made up the centre.

This audit had not only reviewed matters relating to COVID-19 but had also reviewed other areas related to standard infection control precautions. In addition, the audit had identified some infection control risks and the inspector noted these had been suitably addressed prior to the inspection.

There were provisions for segregating dirty laundry, alginate bags were provided and used as part of overall laundry management in the centre and utility facilities provided space for staff to sluice and segregate linen and residents' clothes in a manner that supported good infection control systems.

However, some improvements were required:

- There were aspects of the premises throughout that required refurbishment to ensure all areas were kept to a good standard to ensure adequate cleaning.
- In one living area, colour coded cleaning cloths were stored in the resident's shower/toilet facility.
- Staff working in the centre engaged in the cleaning duties. However, it was not demonstrated that staff had received training in standard precautions and infection control, as set out in the provider's infection control policy. This was to ensure staff were suitably knowledgeable on standard control measures and could implement good practice while performing cleaning duties in the centre.
- The inspector observed a large collection of mould on the ceiling of the utility room space in one living area. While the provider had plans in place to address this issue, at the time of inspection, the mould was present, covered a large section of the ceiling in the room and posed a potential risk of infection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There was a schedule of maintenance in place for fire safety equipment and maintained centrally. This did not provide the local staff or person in charge with information on the outcome of servicing checks, a finding for this is under Regulation 4: Records.

The inspector requested copies of the servicing checks for the centre and these were provided shortly after the inspection. It was demonstrated that all fire equipment servicing records were up-to-date.

Staff had received training in fire safety management with refresher training available and provided as required. There were some staff that required refresher training and one staff required fire safety training.

The evacuation route for one resident living area required review as they did not have an exit door leading from their bedroom. The provider was required to review the personal evacuation route plan for the resident to ensure it was the safest and most efficient route for the resident to evacuate without impacting on the overall containment measures in the centre.

The documented day and night time evacuation procedures for the centre required review to ensure they provided clear and accurate direction to staff on the evacuation routes for each resident within each individual living area. It was not demonstrated that the evacuation procedures provided enough detail to inform staff of what evacuation route each resident was to use during the day and night.

While there were a number of exit routes leading from resident living areas in the centre not all were fitted with an easy open mechanism, such as a thumb turn device. Keys were provided for opening of these doors and were maintained in a container near the doors. However, the inspector observed that the key holders were coded devices which required staff to know the code in order to access the keys. This required review and improvement as it was not a suitable option and could impact on the timeliness of opening doors in the centre.

The provider however, had a comprehensive plan in place to upgrade the fire alarm and emergency lighting system for all designated centres on the congregated 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. A copy of this plan was submitted to the Chief Inspector following the inspection by way of demonstrating an assurance to HIQA that the provider had plans in place to improve fire safety measures in their centres to the most optimum standard.

As this centre was contained within a larger building, the provider was required to ensure they prioritised the fire safety improvements with regards to the fire alarm

for this centre.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents living in this centre had assessed behaviour support needs which required consistent support. Behaviour support plans were in place and residents were supported to also attend mental health reviews.

Overall, there were a low level of restrictive practices, some residents were prescribed medications for the purposes of managing their behaviour support needs which were aligned to their mental health diagnosis and needs.

Some improvement was required to ensure more specific criteria was outlined in residents PRN administration protocols to ensure the criteria for administration was unambiguous and clear.

While most staff had received training in breakaway techniques, staff had not received training in behaviours that challenge and implementation of positive behaviour support. This had also been identified as a finding in the provider's most recent annual report for the centre.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Compliant
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 24 OSV-0005836

Inspection ID: MON-0027676

Date of inspection: 14/03/2022

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The person in charge had only recently commenced in their role in this DC. The person in charge geographical area of responsibility has been reduced with both designated centres are now close in proximity which is more of an appropriate option to ensure effective direct supervision Their remit has since been reviewed which now gives them more effective governance of both their new Designated centres. This reduction has also facilitated effective management of supernumerary time.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A staffing review has occurred with the Director of Care and the need for a staff nurse has been rescinded in favour of recruiting 2 social care staff. Medical oversight will be provided by the pic and clinic nurses on site. There continues to be regular ongoing support with mental health professionals for all residents in the designated centre. Staff will complete behavior support and communication training in the coming months. Staff are also instructed to address further training on HSELand which will enhance their skills in relation to mental health and autism.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All outstanding mandatory training has been addressed since the inspection date with a completion date of 14.04.2022. All new staff will have core mandatory training in place prior to commencement of role. This is part of the induction Programme for all new staff to Stewarts care.
A number of staff have voluntarily completed Safe Administration of Medication training since inspection date. Additional staff have been offered training at the next available dates.
All staff have completed Observing and recording of Seizures training on HSEland since inspection date.
With regards to supervision records, specific areas were identified by the inspector which the person in charge has implemented in quarter 2 of supervision.
The person in charge geographical area of responsibility was reduced and areas in close proximity identified a more appropriate option to ensure effective direct supervision.
The addition of 2 new social care workers in the Designated centre will enhance good quality of care and supervision throughout the designated centre.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Fire servicing records are now maintained on site.
Fire safety records are now maintained on site and staff made aware of the location of same. Staff are encouraged to review these at the monthly staff meetings.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The person in charge has now removed 3 additional sets of documentation noted and there is now one for the entire centre.
Going forward all provider audits carried out will be one for the whole designated centre and not 4 separate living areas.
In the absence of the person in charge the senior service manager will be responsible for ensuring oversight of the centre. The 2 additional social care workers will provide

oversight on the day-to-day operational management of the centre in the person in charge's absence.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The statement of purpose is currently being reviewed and edited to ensure it accurately describes the specific support needs within the centre and the admissions process.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The sensory area for one service user is now complete.
A number of improvements have occurred since inspection.
• Painting completed throughout the designated centre.
• Doors and skirting boards are mostly renovated with some works pending.
• The large shower/toilet area will be reviewed with the resident living in this area.
• Cracked tiles have now been replaced.
• Living area in question has been made more homely.
• Bedrooms have been renovated by painting and adding homely touches – pictures, soft furnishings, new blinds, and curtains in line with resident's wishes.
• Flooring replacement is partially completed with impact of holidays and unexpected leave impacting on same. Remains to be completed in coming weeks.
All 4 Living areas have been improved since the inspection with painting and furnishings.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
There is now overarching risk document for the four centers as merged by the person in charge.
A control measure to prevent a risk of burns from a radiator is currently underway. A

specific radiator cover needs to be specially built. This will be completed and in place by the 20/05/2022

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: Large refurbishment has occurred since the inspection with all actions near completion. Colour coded cleaning cloths have been removed from the area in question and all stored in a designated area in each unit. All Staff have completed IPC and hand hygiene training since this inspection. The mould has been removed, area treated and refurbished.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Refresher training has been completed since time of inspection with all staff up to date. All personal evacuation plans were reviewed and are clearly stating evacuation routes. Evacuation routes will remain on the agenda for monthly team meetings. Maintenance of fire safety systems are in place and records are currently kept online within the Technical Services Department. ICT have granted access for all Persons in charge to access these, fire extinguisher service certificates are currently received from the provider who completes the servicing and issues to all locations. Day and night time evacuation procedures have been reviewed and provides clear direction to staff in the event of an emergency/ fire. Evacuation of one resident has been reviewed by the fire officer and clear information provided to Person in Charge and staff members. Primary and secondary escape routes have been reviewed. For one resident in particular the service user does not require a door within the bedroom, and has escape routes which are clearly defined and are within normal travel distances to evacuate the resident in a safe manner. Thumb turn devices are now installed within the designated centre. New emergency exit signage has been completed in the designated centre. New fire doors providing effective containment have been recently installed within the designated centre. Entrance doors have been installed on April 20th. The fire detection and alarm systems are currently been designed throughout all homes

by fire consultant and electrical engineer. Key codes are currently been eliminated at final exits and replaced by electronic key pads.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: PRN medication administration protocols were reviewed on the date of inspection to clarify the language to ensure greater clarity. Behavior support training is in progress and scheduled for completion with all staff by the end of May 2022	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	13/04/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2022
Regulation 15(2)	The registered	Not Compliant		31/03/2022

	provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.		Orange	
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	14/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2022
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	31/05/2022
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	Substantially Compliant	Yellow	31/05/2022

	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.			
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Substantially Compliant	Yellow	04/04/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	30/06/2022
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'	Substantially Compliant	Yellow	30/06/2022

	needs, consistent and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	14/04/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	14/04/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	09/05/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including	Not Compliant	Orange	14/04/2022

	emergency lighting.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	14/04/2022
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Substantially Compliant	Yellow	14/04/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	14/04/2022

Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	06/05/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/05/2022
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	14/04/2022