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 10
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	28 January 2021
Centre ID:	OSV-0005842
Fieldwork ID:	MON-0027757

About the designated centre

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

This centre aims to support and empower people with an intellectual disability to live meaningful and fulfilling lives. The centre provides long term residential support to no more than 10 men and women with complex support needs. The centre is a wheelchair accessible bungalow with 10 private bedrooms for residents, a large communal living room, dining room, family room, multi-sensory room and music room. Healthcare is provided by residents' General Practitioner along with allied healthcare professionals and the centre is staffed by both nursing staff, health care assistants and an activity staff member. The centre has a full time clinical nurse manager to supervise the staff team.

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
Thursday 28 January 2021	12:45hrs to 18:00hrs	Andrew Mooney	Lead

What residents told us and what inspectors observed

In line with public health guidance and residents' assessed needs, the inspector did not spend extended periods with residents. However, the inspector did have the opportunity to observe residents in their home for a limited period. The inspector used these observations, discussions with staff and a review of documentation, such as resident questionnaires to inform their judgements. Overall, the inspector found that residents' lived experience within the centre were being adversely impacted due to the number and mix of people residing within the centre.

During a walk around of the centre, the inspector observed a busy environment. There were 10 residents living in the centre, some with complex care and support needs. Theses 10 residents were supported by four care staff, a day activation staff member and two staff nurses. The cumulative impact of the number of residents and staff led to a very busy environment that was not homely. The inspector observed staff supporting residents with all areas of daily living in a calm and respectful manner. Residents not being supported, were generally sitting in communal areas watching television or resting in their bedrooms. Where possible residents were supported to go on drives in the community.

There were three main communal areas within the centre. However, these areas were not all available to residents during the day. Some were assigned for individual residents, to support them with their assessed support needs. These arrangements were in place due to long standing compatibility issues among residents and to ensure safeguarding plans could be implemented. However, these measures also contributed to a very busy feel within the centre.

At the time of inspection the provider had implemented all appropriate guidance in response to the COVID-19 pandemic. Unfortunately, this did limit residents access to community activities but was in keeping with current public health guidance. Furthermore, visitor access was limited to essential access only. The provider had contingency arrangements in place where, when appropriate and in line with public health guidance, visitors could meet residents in a safe manner.

A review of resident questionnaires noted that while they were very happy with staff they were challenged by others aspects of the centre. Generally, residents said the environment was too noisy and that they felt that too many people were living in the centre. One resident stated in their questionnaire "I like peace and quiet and being among 10 service users its not always possible to get out on bus trips". Another resident stated its" very noisy and too many service users here".

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

This inspection found that the current governance and management arrangements required improvement. Overall the governance and management arrangements within the centre did not ensure sufficient progress was made with the centres agreed de-congregation plans and this led to residents' lived experience within the centre being poor. Furthermore, improvements were required in staffing levels, to ensure residents' assessed needs could be met at all times.

The inspector found that the centre was managed by a suitably qualified, skilled and experienced person. The person in charge was found to have a good knowledge of the care and support requirements for residents living in the centre and was in a full time post.

There was a management structure in place that identified the lines of accountability and responsibility. However, the governance arrangements in place were not robust and this meant that the lines of accountability and responsibility were not clear. For instance the provider had deployed staff from other parts of the campus to work in the centre at night, these staff did not report to the person in charge directly. This led to the person in charge not having full oversight of staff working within the centre at night.

Furthermore, a review of the centres progress with their compliance improvement plan, which was linked to a restrictive condition of their registration, found that insufficient progress had been made with this plan. For example, the centres' compliance improvement plan had identified that resident numbers within the centre should reduce to eight by the end of 2019 and to seven by the end of 2020. These discharges had not occurred and there was no formal transition plans available to review during the inspection. This lack of progress on the centres de-congregation plans, negatively impacted residents' lived experience within the centre.

It was unclear from a review of the staff rota if there was sufficient staff to meet the assessed needs of residents at all times. The person in charge outlined that the centre required two night time staff to safely meet residents' assessed needs. However, the current staffing whole time equivalent did not allow for this level of support and therefore, the centre relied upon staffing resources from the campus to fill half of all night time staff. The person in charge outlined that they did not have oversight of these staff and there was no formal structure in place within the designated centre to record if these staff were present or not. Furthermore it was unclear if staff working in the centre at night had the required competencies to support residents who required nursing care. An immediate action was issued in relation to this and the provider gave assurances that measures had been put in place to ensure residents had access to nursing care at night. There was a planned and actual rota in place but it required improvement, as the current rota did not clearly identify the hours worked by each staff on duty in the centre. The inspector briefly engaged with staff during the inspection and observed their practice. The

inspector found staff to be knowledgeable about their role and residents' needs. Staff were observed supporting residents in a kind and compassionate manner during the inspection.

Staff were provided with suitable training such as fire safety, manual handling, positive behaviour support infection control. There were some gaps in this training but the provider was aware of these gaps and had made arrangements to address them and ensured all mandatory training was provided. The provider had a staff supervision system in place and staff received appropriate supervision.

Regulation 14: Persons in charge

The centre was managed by a suitably skilled, qualified and experienced person in charge.

Judgment: Compliant

Regulation 15: Staffing

It was unclear if the current staffing arrangements were sufficient to meet the assessed needs of residents at all times. For example the centre relied on external staffing resources based on the campus to cover half of all night time staffing.

It was unclear if nursing care was consistently available at night, in line with residents' assessment of needs. For example nursing staff were not noted consistently at night on the rota.

The rota required improvement to ensure it reflected all staff members that worked in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The education and training available to staff enabled them to provide care that reflected up-to-date practice. Appropriate refresher training had been completed and/or was scheduled. Staff were supervised appropriate to their role.

Judgment: Compliant

Regulation 23: Governance and management

The governance and management arrangements in place were not robust and this meant that the lines of accountability and responsibility were not clear. For instance the provider had deployed staff from other parts of the campus to work in the centre at night, these staff did not report to the person in charge directly. This led to the person in charge not having full oversight of staff working within the centre at night.

The provider had ensured that an annual review of quality and safety of care was completed. However, this review did not take account of the National Standards. Furthermore, while the provider had ensured that an unannounced inspection of the centre was completed every six months, these inspections required improvement. They failed to adequately self-identify pertinent areas of non compliance, such as the lack of progress being made with the centres de-congregation plan and transitions from the centre.

Judgment: Not compliant

Quality and safety

Overall this inspection found that the current configuration and arrangements within the centre adversely impacted the quality and safety of the centre. Arrangements for supporting residents with emergency healthcare needs, required immediate improvement. Furthermore, the centres configuration led to some residents being exposed to persistent behaviours of concern and a crowded environment.

Generally residents healthcare needs were supported appropriately. Residents had good access to healthcare supports, such as a General Practitioner (GP) of their choice and access to a variety of multi-disciplinary supports such as dietitians, occupational therapists and speech and language therapy. However, residents' emergency healthcare needs could not always be met, as they were not consistently supported with appropriately trained staff. For instance residents who may require emergency medicines relating to their assessed healthcare needs were accompanied in the community without suitably qualified staff. They therefore could not be administered this medicine in accordance with their agreed healthcare plans.

A review of documentation within the centre identified that there had been a high level of reoccurring behaviours of concern. For instance a resident had presented with 188 behavioural incidents in the previous 12 months. These incidents were frequently observed or heard by other residents living in the centre and included incidents of self injurious behaviour and long periods of shouting. Behaviour incident record forms noted that the strategies used to support the resident had mixed effectiveness. However, the resident's behaviour support

plan and the strategies contained within it, had not been formally reviewed since they were implemented in 2015 and therefore it was unclear if these strategies were effective to support the resident with their assessed needs. This lack of review had been identified by the person in charge and a request had been made for these plans to be reviewed by the relevant multi-disciplinary department. However, at the time of inspection, it was unclear if these reviews had been completed. The frequency of these incidents and the necessary arrangements put in place to safeguard residents adversely impacted the homely feel within the centre.

There were arrangements in place to ensure that each resident had a comprehensive assessment of need and a personal plan in place that detailed their needs and outlined the supports required to maximise their personal development and quality of life. However, not all aspects of residents' assessed need were appropriately reviewed annually as required, such as behaviour support plans. Additionally, longstanding compatibility issues had been identified by the provider and it was therefore unclear if arrangements were in place to ensure that the designated centre was suitable for the purpose of meeting the needs of each resident. For example, a review of residents' documentation noted a recommendation that a resident would benefit from living with a smaller group of people. The plan highlighted that this resident should not be matched with high dependency service users. Furthermore, despite these compatibility issues being identified in 2015 and the provider's compliance improvement plan noting that by the end of 2020 there should be no more than seven residents living in the centre, no clear transition planning was in place or available for review.

The provider had systems in place to safeguard residents from all forms of potential abuse. All incidents, allegations and suspicions of abuse at the centre were investigated in accordance with the centre's policy. Staff had a good understanding of safeguarding processes and this limited the impact of potential safeguarding incidents.

There were clear arrangements in place to protect residents and staff from acquiring or transmitting COVID-19. There were procedures in place for the prevention and control of infection. Suitable cleaning equipment was in place and stored appropriately. Sufficient facilities for hand hygiene were observed and hand hygiene posters were on display. There were adequate arrangements in place for the disposal of waste. The provider had developed an appropriate COVID-19 contingency plan, which included adopting relevant public health guidance, such as daily staff temperature checks. The provider engaged regularly with the Department of Public Health and made key information in relation to infection control measures available to staff.

The centre had a risk management policy in place for the assessment, management and ongoing review of risk. This included a location-specific risk register and individual risk assessments which ensured risk control measures were relative to the risk identified. The person in charge and provider had ensured that pertinent risks were place on the register and were reviewed regularly. This included risk assessing the potential impact of residents and staff acquiring COVID-19, how to support

residents to safely use their community and visiting relatives.

The provider had ensured that there were fire safety measures in place, including detection and alarm system, fire fighting equipment and containment measures. There were personal evacuation plans in place for all residents and staff understood what to do in the event of a fire. Regular fire drills were conducted within the centre. However, these drills required improvement as they did not demonstrate that the centre could be safely evacuated when the maximum number of residents were on site and the minimum number of staff on the rota were available.

Regulation 25: Temporary absence, transition and discharge of residents

Discharges from the centre had not been completed in accordance with residents' assessed needs. For example the centres' compliance improvement plan had identified that resident numbers within the centre should reduce to eight by the end of 2019 and to seven by the end of 2020. These discharges had not occurred and there was no formal transition plans available to review during the inspection.

Judgment: Not compliant

Regulation 26: Risk management procedures

Arrangements were in place to ensure risk control measures were relative to the risk identified.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had introduced a range of measures to protect residents and staff from acquiring COVID-19. These arrangements included excellent infection control procedures, the use of appropriate PPE (Personal Protective Equipment), social distancing, good hand washing facilities, hand sanitising facilities, clinical waste arrangements and laundry facilities.

Judgment: Compliant

Regulation 28: Fire precautions

There were appropriate systems in place for the prevention and detection of fire and all staff had received suitable training in fire prevention and emergency procedures.

Regular fire drills were taking place, however they required some improvement as they were not reflective of all possible fire scenarios. For example, these drills did not demonstrate that the centre could be safely evacuated when the maximum number of residents were on site and the minimum number of staff on the rota were available.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The current arrangements in place within the centre did not ensure each residents' assessed needs were met. For instance the provider had self identified that the centre was not suitable to meet all residents assessed needs.

Not all assessments of need were reviewed annually, for example positive behaviour plans.

Judgment: Not compliant

Regulation 6: Health care

Residents' emergency healthcare needs could not always be met, as they were not consistently supported with appropriately trained staff. For instance residents who may required emergency medicines relating to their assessed healthcare needs were accompanied in the community without suitably qualified staff. They therefore could not be administered this medicine in accordance with agreed their healthcare plans.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There was a high volume of reoccurring behaviours of concern within the centre and it was unclear if the measures put in place were effective in supporting residents with their assessed needs..

Judgment: Not compliant

Regulation 8: Protection

The person in charge initiated and carried out an investigation in relation to any incident, allegation or suspicion of abuse and took appropriate action where a resident was harmed or suffered abuse.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 10 OSV-0005842

Inspection ID: MON-0027757

Date of inspection: 28/01/2021

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: A recent review of staffing by the provider in the DC identified the need for an additional nurse. This review was completed by the Care management team and members of the executive management through the providers DNA review meeting. The additional staff nurse was implemented at the start of the year with one additional staff nurse on each day shift. A nursing deficit at night was identified through this inspection. Since the inspection there is now a staff nurse and HCA on each night in the DC and this is reflected on the roster by the PIC.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Since the inspection there is now a staff nurse on each night in the DC. The staff nurses that work nights in the DC now report directly to the PIC who has responsibility for their ROTA management and supervisions The unannounced 6 monthly inspections had been reviewed at the start of the year with changes made on the template with a section on de-congregation and transitions from centers. The 2020 annual reviews has been tested against certain elements of the National Standards, while also determining how much progress has been made on the DC by	

implementing outstanding issues from 2019s annual reviews and from the most recent provider visit. This will enable a continuous approach to quality and improvement across the service.

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

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents: 3 residents will move into a home on campus that is currently vacant. This home is expected to be ready for the 3 residents to move into by the end of July 2021. One other resident has a transition plan completed to move into a community home by the end of the year. DC 10 will then have no more than 6 residents by the end of 2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A fire drill was completed on the 22nd of February with the maximum number of residents and minimum number of staff. All residents were evacuated safely and fire drill report was forwarded onto the fire officer manager.

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: 3 transitions will happen before the end of July 2021 and one further transition by the end of the year. All PBSPs have since been reviewed and updated on the 26th of February.

Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: House meeting completed on the 18th of February. Discussion had with staff about midazolam training for all staff who work nights and support residents with external activities. At present 2 staff are booked onto the course and additional staff will have completed the training by the end of June 2021. Additional training has been put on by education and training department.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All PBSPs have since been reviewed and updated on the 26th of February.	

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	31/07/2021
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Red	28/01/2021
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the	Substantially Compliant	Yellow	07/02/2021

	day and night and that it is properly maintained.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	07/02/2021
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	31/07/2021
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/04/2021
Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential	Not Compliant	Orange	31/07/2021

	services through:the provision of information on the services and supports available.			
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	22/02/2021
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 than on an annual basis.	Substantially Compliant	Yellow	30/06/2021
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,	Not Compliant	Orange	31/07/2021

	as assessed in accordance with paragraph (1).			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/06/2021
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.	Not Compliant	Orange	31/03/2021