



**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 27
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Announced
Date of inspection:	06 April 2022
Centre ID:	OSV-0005855
Fieldwork ID:	MON-0027734

About the designated centre

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

Designated Centre 27 is operated by Stewarts Care Limited. The centre provides long stay residential support for up to eight women with complex support needs. The centre aims to support people with an intellectual disability to live meaningful and fulfilling lives by delivering quality, person-centred services, provided by a team of nurses and care assistants. The centre is located on the provider's congregated campus in South Dublin. It is comprised of one bungalow with eight single occupancy bedrooms, a large living area, two dining areas, a small kitchen, four bathrooms, a multi-sensory room and utility room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8
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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
Wednesday 6 April 2022	10:00hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

This report outlines the findings 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. Residents living in the centre were unable to provide verbal feedback about the service, therefore the inspector carried out observations of residents' daily routines and of their home and support arrangements.

The centre consisted of one residential bungalow situated on a congregated campus setting. Observations carried out in the home noted it was nicely decorated and efforts had been made to make it as homely as possible. Some premises improvements were required to ensure the centre was maintained to a good standard and could provide residents with the most optimum service provision.

For example, most resident bedrooms were very small. Residents bedrooms consisted of a single bed, a sink, a small wardrobe and a chest of drawers. There was limited space for residents to engage in personal hobbies or private activities in their bedroom spaces due to the lack of circulation space in the rooms.

While overall, the designated centre appeared clean, there were aspects the inspector observed were not maintained in the most optimum standard.

Both shower room areas of the home required improvement. The inspector observed a collection of mould build up and cracked paint on the ceiling of one of the shower rooms. In the other shower/toilet room there was observable peeling plaster on the walls and part of the ceiling had a large water stain. A mobile curtain rail was utilised in one of the shower/toilet rooms which was not the most optimum provision and posed a potential hazard if it fell over and could not ensure optimum infection control and hygiene standards if used on a long term basis.

The inspector also observed marks on the walls in a number of circulation and bathroom areas required repainting where they had been repaired or filled in but not painted over yet.

Other aspects of the premises were pleasant and homely and it was observed the provider had made a number of premises enhancements. For example, the centre was provided with a small kitchen area with well maintained kitchen units and worktops. A well proportioned sensory room was also available to residents and a

large dining room area was also provided. The living room area was fitted out with comfortable seating and a large flat screen TV with a good selection of TV channels.

Residents' bedrooms, albeit small, were individually decorated and personalised as much as possible and were clean and tidy.

The provider had also made provisions for a utility space that contained a washing machine, dryer and sink area with counter space and cupboards for storing laundry detergent and alginate bags, for example.

On the day of the inspection, the inspector observed staff engaging in a pleasant way with residents and encouraging them to dance along with music and dancing with residents in the living room space at one point during the inspection.

All residents living in the centre required supports with modified diets to ensure their best possible nutrition. The centre provided two dining room areas with well spaced out tables and chairs which could support staff to sit with residents while providing them support with their meals. There were provisions in the kitchen space for chopping or chopping food that arrived to the centre from the centralised kitchen.

Some staff spoken with demonstrated the additional food supplies in the kitchen space where snacks could be prepared for residents during the day. There were provisions in place by the provider to ensure meals could be heated and prepared to the appropriate consistency for residents living in the centre who all required modified consistency meals.

Some improvement was required however, to ensure staff were appropriately knowledgeable and skilled in preparing modified consistency meals and responding to incidents of risk or distress presented by residents with compromised swallow. This is further outlined in the quality and safety section of the report.

The inspector reviewed aspects in relation to fire safety precautions. While overall, the provider had put good containment systems in place and provisions for ensuring timely and effective evacuation of residents with the provision of fire evacuation aids, further improvement was required.

The fire panel for the bungalow was located outside of the building. The fire alarm system could alert staff of the presence of a potential fire with the sound of the alarm activating within the bungalow itself. However the fire panel could not identify, for staff, the exact location that triggered the alarm in the respective bungalow. Therefore, staff did not use the fire panel as part of the evacuation procedures as it was not accessible or addressable. The provider had however, identified a suite of fire upgrade works were required across the congregated campus setting and had a phased plan to address this.

Some additional fire safety improvement was also required in the centre in relation to containment measures and ensuring all areas of the home, in particular high risk areas, were provided with detection systems for the purposes of good fire safety systems. The provider, however, undertook to address these matters within a short time-frame following the inspection, therefore mitigating the fire safety risks

identified during the course of the inspection. This is also further outlined in the quality and safety section of the report.

In summary, residents living in this designated centre were experiencing good care with some areas that required improvement in relation to staff training in nutrition, modified consistency diets and the management and response to risk incidents associated with dysphagia and pica (consuming inedible substances).

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 this 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 reasonably good standard of care.

Overall, it was noted there had been a considerable drive by the provider to audit and review the quality of the service in advance of the inspection and a number of quality improvements had been addressed or were in the process by the time of the inspection.

Information, for the purposes of processing the registration renewal of the centre, had been submitted to the Office of the Chief Inspector as 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 and one other designated centre, both located in close proximity on the grounds of the congregated campus. It was found that they had the appropriate qualifications and management experience to meet the requirements of Regulation 14.

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 also comprehensive and provided an improvement action plan to bring about enhanced compliance.

As discussed, the provider had carried out a considerable scope of auditing and reviews prior to the inspection. Relevant appropriately qualified stakeholders had carried out audit reviews of fire safety, risk management, safeguarding and infection control in the centre. An overarching quality and compliance tracker was in place which incorporated an action plan for improvement and included the findings from the provider's six-monthly provider-led audits and additional audits that had been carried out.

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.

The person in charge had ensured staff were appropriately trained in mandatory areas of safeguarding, fire safety and manual handling to meet the needs of residents. Some improvement was required to ensure staff had received additional skills training to meet the assessed needs of residents in this centre in the areas of dysphagia care and positive behaviour support.

While it was demonstrated some staff had received online training in providing supports for residents with modified nutritional needs, not all staff had completed this training.

The inspector asked some staff about how they supported residents with their modified consistency meals and their knowledge of how to respond to incidents where residents may experience difficulty or distress during mealtimes as a result of their compromised swallow. The inspector was not fully assured that staff were suitably knowledgeable on the types of foods that suitable to be modified for residents. In addition, not all staff spoken with were able to provide the inspector with a sound demonstration of their knowledge on how to respond to incidents of distress or choking for residents with compromised swallow. This required improvement.

The person in charge maintained a planned and actual roster. The inspector reviewed the rosters for the centre over the previous weeks and noted overall the staffing levels in the centre had been maintained within the whole-time equivalent (WTE) numbers as set out in the statement of purpose. There had been some staff changes in recent times and new staff had begun working in the centre.

Rosters for the centre clearly demonstrated full staff names, their role and the hours worked in the centre.

Regulation 15: Staffing

The person in charge maintained planned and actual rosters. These clearly outlined the full name of staff, the shifts that staff were working and their role.

On review of staffing rosters it was demonstrated the staffing levels and skill-mix were maintained to the levels as set out in the whole-time-equivalent numbers of the statement of purpose.

The working roster for the person in charge was also maintained and demonstrated the shifts and hours they worked each week.

Schedule 2 staff files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

While some staff had received online training in the area of dysphagia care, not all staff had completed the training. Of the training provided, it was not evident that additional practical skill training or skill assessment had been carried out in the centre.

From speaking with some staff, the inspector was not fully assured they were suitably knowledgeable on the types of foods that could be modified in line with residents' dysphagia management plan.

In addition, not all staff spoken with were able to provide the inspector with a sound demonstration of their knowledge on how to respond to incidents of distress or choking for residents with compromised swallow

This required improvement as all residents living in this centre required support and intervention with regards to dysphagia management and had associated modified consistency meal planning arrangements in place.

Not all staff had received training in the area of positive behaviour support. This was required as some residents living in the centre required behaviour support planning and interventions.

The person in charge had carried out supervision meetings with staff as per the the provider's supervision policy and procedures. There were suitable arrangements to ensure an assigned person was present in the centre to supervise and guide staff practice each day.

Judgment: Not compliant

Regulation 23: Governance and management

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

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.

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.

The provider had appointed a full-time person in charge for the centre that met the requirements of Regulation 14.

The provider had ensured there were clear lines of responsibility and reporting for the management oversight of the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

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

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked in a full-time capacity and was responsible for this designated centre and another centre, located in close proximity on the congregated campus setting.

The provider had made arrangements to ensure the person in charge had a reasonable management remit by ensuring each designated centre they managed consisted of only one bungalow.

The person in charge had the required management qualifications and experience to meet the requirements of regulation 14.

Judgment: Compliant

Quality and safety

This inspection found that residents were in receipt of a good service, for the most part, that was meeting their social and health care needs within the context of COVID-19. Improvements were required in the area of fire safety arrangements, food and nutrition and enhancement of personal planning for specific assessed needs of residents that presented with pica related needs.

There was a schedule of maintenance in place for fire safety equipment. The inspector reviewed servicing check records and noted they were up-to-date. The designated centre had undergone a fire safety audit by a stakeholder of the provider with a remit in fire safety which identified where improvements were required and action plans had been put in place to address these, with a number of the areas identified addressed prior to the inspection.

Recorded fire drills had been carried out and documented records of these were maintained in each residential bungalow. Staff had received training in fire safety management with refresher training available and provided as required. Personal evacuation plans were in place for each resident.

Improvements were required however.

Containment measures were, for the most part, in place in the designated centre. Fire doors were fitted with door closers and smoke seals. However, the door to the utility room, that contained the washing machine and dryer, was not a fire door and did not have a door closer or smoke seal fitted. This required improvement to ensure optimum containment measures for the preventing the spread of fire and smoke were in place.

In addition, the inspector noted there were no smoke/heat detection systems in place in the utility room. This meant that the fire safety detection systems in the centre were not monitoring all areas of the home and therefore, while fire systems were in place, they were not fully effective.

Shortly following the inspection, the provider undertook to address these fire safety risks by installing a smoke/heat detector in the utility room and a containment fire door leading from the utility room. The provider also submitted evidence of the installation of these fire safety systems to the inspector by way of demonstrating they had completed these works. Therefore, the fire safety risks, found on inspection, were promptly addressed by the provider to an appropriate standard.

The fire alarm panel for the bungalow was located outside the premises. The location of the panel required review as it was not readily accessible for staff and in

addition were not addressable and therefore not used as part of the evacuation procedures for 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 by way of demonstrating an assurance to that the provider had plans in place to improve fire safety measures in their centres to the most optimum standard in a phased manner and would include this designated centre.

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 public health guidance.

The provider had ensured a comprehensive infection control audit of the designated centre had been completed by a clinical nurse specialist in Infection Control. 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 areas for improvement, some of which had been addressed by the time of inspection.

However, some additional infection control standards required improvement. There was the presence of noticeable mould on the ceiling in one of the shower/toilet rooms.

At the time of inspection, staff were disposing used latex gloves into small containers that only staff could open, at key locations in the centre. This was an interim risk management measure put in place for the safe disposal of latex gloves to prevent a pica related personal risk for some residents. While this risk control measure was a suitable short-term measure to manage the risk, it did impact on the promotion of good infection control standards on infectious waste management as it required staff to open the receptacle by hand and place gloves into the container and reseal it again.

While these ensured residents could not remove the gloves from the containers, which could pose a risk to some, it did result in staff not being able to dispose of soiled latex gloves in a manner that promoted good hand hygiene. The inspector however, did acknowledge that this was an interim risk management measure and the person in charge and provider were reviewing more optimum infection control and risk management systems for use in the longer term in the centre.

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.

The person in charge also carried out a process of reviewing incidents occurring in the centre, establishing trends and using this information to inform analysis of the risk presenting in the centre. This ensured risks that were assessed were accurate with an appropriate risk rating for each.

As discussed, due to an identified personal risk for some residents, the storage and disposal of latex gloves required comprehensive management in order to mitigate any risk to residents. The inspector observed the interim risk management systems that the provider and person in charge had put in place on foot of a recent incident. The inspector noted that the immediate risk management initiative implemented had been carried out quickly and was effective. All staff spoken with demonstrated a good knowledge of why the system had been put in place and how they implemented it.

It was observed that the provider had endeavoured to provide residents with a homely environment. Residents' bedrooms were nicely decorated and personalised. Residents were also provided with mobility aids and equipment to meet their assessed needs. However, as discussed, residents' bedroom spaces were small and limited in circulation space for residents to spend time in their bedrooms. Some areas of the home required refurbishment.

Each resident had received an assessment of need with support planning arrangements in place for each need identified. There were improvements required however, to ensure staff were provided with clear guidance and direction on the management of the assessed needs for some residents.

For example, while there was observable and documentary evidence of risk management measures being put in place to mitigate the risk of pica. It was not demonstrated that there were guidance procedures or documented plans in place to guide and direct staff on how to respond to a suspected or actual emergency incident of pica.

The provider had provided the centre with a separate kitchen area that had been upgraded in recent times to ensure a clean and usable space for staff to prepare residents' meals and snacks.

The inspector observed the kitchen area was clean and hygienic throughout and there were suitable food storage space for condiments, dry goods and fresh food. Residents main meals were delivered from a centralised kitchen and prepared in the kitchen before meal times. Provisions were also in place for staff to modify residents' meals as required.

However, some improvement was required.

The inspector noted some residents required nutrition planning arrangements to manage high cholesterol and weight management. Other residents were prescribed

diabetes management medication but it was not evident that there was an associated diabetes diet/nutrition guidelines plan in place.

On review of nutritional plan recommendations for residents it was demonstrated that these plans were considerably out-of-date with those reviewed dated 2014.

It was noted that some residents had been referred for review of their nutrition plans since that date but, due to resources constraints at that time, they had not received a dietetic review and therefore, their nutrition plans had not been updated.

Regulation 17: Premises

Overall, the premises was maintained to a reasonably good standard.

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.

Residents were provided with single occupancy private bedrooms, a separate kitchen area, a large dining room space with seating options, comfortable living room space and a separate sensory room.

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

- Resident bedrooms were very small in size and were limited in space for residents to spend time in and engage in personal hobbies or private time.
- Some areas of the centre required re-painting or touch ups to manage general wear and tear.
- There were upgrades required in both toilet/shower rooms where there were cracks in the paintwork on the ceilings, areas that had been filled or plastered over on the walls but not finished or painted over.
- Large water stain mark on the ceiling of one shower/toilet room.
- A metal mobile shower curtain was being utilised in one toilet/shower room. This required review to ensure a more optimum arrangement was put in place to provide privacy arrangements for residents during personal bathing.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

It was demonstrated that there were suitable provisions in place to ensure residents were provided with nutritious meals, drinks and snacks at regular times.

There was an overall good standard of hygiene observed in the kitchen and dining area of the centre and the provider had ensured suitable provisions were in place to the storage of fresh and dry goods in the centre.

There were improvements required in relation to the updating and creation of documented nutritional plans.

The inspector noted some residents required nutrition planning arrangements to manage high cholesterol and weight management. Other residents were prescribed diabetes management medication but it was not evident that there was an associated diabetes diet or nutritional guidelines plan in place.

On review of nutritional plan recommendations for residents it was demonstrated that these plans were considerably out-of-date with those reviewed dated 2014.

It was noted that some residents had been referred for review of their nutrition plans since that date but, due to resources constraints at that time, they had not received a dietetic review and therefore, their nutrition plans had not been updated.

The provider and person in charge were required to ensure a dietetic review of meals and snacks provided in the centre was carried out, to ensure they were suitable to meet their nutritional needs of all residents and were in line with their health and speech and language assessments and recommendations and to make arrangements for each residents' nutritional care plan to be updated and ensure all staff were knowledgeable of the changes.

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.

The person in charge also carried out a process of reviewing incidents occurring in the centre, establishing trends and using this information to inform analysis of the risk presenting in the centre. This ensured risks that were assessed were accurate with an appropriate risk rating for each.

Some residents in the centre presented with behaviours that presented personal risks associated. The person in charge had updated the risk register to reflect this risk and there was observable evidence to demonstrate the person in charge and provider had taken responsive action to mitigate the immediate risks presenting by putting interim measures for the purposes of disposing of latex gloves.

Judgment: Compliant

Regulation 27: Protection against infection

It was noted good COVID-19 outbreak 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 for each residential home 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 segregate linen and residents' clothes in a manner that supported good infection control systems.

However, some improvements were required:

- There was a collection of mould on the ceiling in one toilet/shower room.
- An interim measure for the management of risks associated with latex gloves required review and the implementation of a longer term solution so as to ensure effective waste management in the centre which, not only mitigated personal risks to residents, but also ensured optimum infection control standards in the area of hand hygiene and infectious waste disposal.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire equipment for the centre had been serviced and up-to-date records maintained.

Recorded fire drills had been carried out and documented records of these were maintained in the centre.

Staff had received training in fire safety management with refresher training available and provided as required.

Personal evacuation plans were in place for each resident.

Containment measures were, for the most part, in place in the designated centre. Fire doors were fitted with door closers and smoke seals. However, the door to the utility room, that contained the washing machine and dryer, was not a fire door and did not have a door closer or smoke seal fitted. This required improvement to ensure optimum containment measures for the preventing the spread of fire and smoke were in place.

In addition, the inspector noted there were no smoke/heat detection systems in place in the utility room. This meant that the fire safety detection systems in the centre were not monitoring all areas of the home and therefore, while fire systems were in place, they were not fully effective.

Shortly after the inspection, the provider undertook to address these fire safety risks by installing a smoke/heat detector in the utility room and a containment fire door leading from the utility room. The provider also submitted evidence of the installation of these fire safety systems to the inspector by way of demonstrating they had completed these works. Therefore, the fire safety risks, found on inspection, were promptly addressed by the provider to an appropriate standard.

The fire alarm panel for the bungalow was located outside the premises.

The location of the panel required review as it was not readily accessible for staff and in addition were not addressable and therefore not used as part of the evacuation procedures for 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.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had received an assessment of need with support planning arrangements in place for each need identified. There were improvements required however, to ensure staff were provided with clear guidance and direction on the management of some assessed needs for residents.

For example, while there was observable and documentary evidence of risk management measures being put in place to mitigate the risk of pica, it was not demonstrated that there were guidance procedures or documented plans in place to guide and direct staff on how to respond to a suspected or actual emergency incident of pica.

On review of the planning arrangements in place regarding pica management, the inspector noted there were no such plans currently in a resident's personal plan. On further review the person in charge did source a care plan, however, it had been de-activated on the electronic system and therefore, was not in date.

The person in charge was required to develop a pica management plan which reflected recommendations and directions by relevant multi-disciplinary allied professionals.

This was to ensure the documented procedures and response plans were in line with clinical best practice and recommended emergency response procedures and interventions relevant to the risk posed by consuming an inedible substance.

Dietetic/nutritional plans were considerably out-of-date and had not been reviewed by an appropriately qualified allied professional since being put in place in 2014.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 14: Persons in charge	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 27 OSV-0005855

Inspection ID: MON-0027734

Date of inspection: 06/04/2022

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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The person in Charge has addressed to SALT that additional practical skill training or skill assessment is required and has provided FEES and food modification to staff and was completed on 30th April 2022.</p> <p>The Person in Charge has implemented on 7th of April 2022 during handovers and team meetings that the types of foods that could be modified in line with Residents' dysphagia management plan are discussed.</p> <p>The Person in Charge has ensured that one Staff on each shift is trained in First Aid on 27th April 2022 so they can demonstrate their knowledge on how to respond to incidents of distress or choking for residents with compromised swallowing. Other Staff will be trained by end of July 2022.</p> <p>The Person in Charge has ensured Staff identified during Training audit will receive training in the area of positive behaviour support by end of June 2022.</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> • The Person in Charge is liaising with Transition Team to transition 2x Residents out of the Designated Centre by end of August 2022. Resident bedrooms size will be revisited following these transition. • The Person in Charge is liaising with Technical Services to re-paint some areas of the centre that require re-painting or touch ups to manage general wear and tear. 	

- The Person in Charge has liaised with the Technical Service department to carry out necessary painting to remove the large water stain mark on the ceiling of one shower/toilet room.
- The Person in Charge has purchased a brand new metal mobile shower curtain to be utilised in one toilet/shower room. A new shower door is to be installed in the shower room to provide privacy arrangements for residents during personal bathing by end of August 2022.

Regulation 18: Food and nutrition

Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

The provider and person in charge were required to ensure a dietetic review of meals and snacks provided in the centre was carried out, to ensure they were suitable to meet their nutritional needs of all residents and were in line with their health and speech and language assessments and recommendations and to make arrangements for each residents' nutritional care plan to be updated and ensure all staff were knowledgeable of the changes.

The Provider has the Dietician role been advertised as there is vacancy at present. The Person in Charge has support of GP and Director of Clinical Services to monitor diabetic status of Residents through annual medical review and evidence based practice. Diabetic levels are controlled at present. Any anomalies will be addressed by GP till the position of Dietician is filled.

Regulation 27: Protection against infection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

- An interim measure for the management of risks associated with latex gloves required review and the implementation of a longer term solution so as to ensure effective waste management in the centre which, not only mitigated personal risks to residents, but also ensured optimum infection control standards in the area of hand hygiene and infectious waste disposal.

The Technical Services department has informed the Person in Charge that the toilet/shower room is been renovated by end of June 2022.

The Person in Charge with support from Infection Prevention Control Officer has sourced a sanitary bin on 13th May 2022 for trial in the management of risks associated with latex gloves. The sanitary bin is on trial for 2 weeks and will be reviewed for further action.

Regulation 28: Fire precautions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
 The provider has installed a smoke/heat detector in the utility room and a containment fire door leading from the utility room. The provider has submitted evidence of the installation of these fire safety systems to the inspector by way of demonstrating they had completed these works.

Regulation 5: Individual assessment and personal plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
 Dietetic/nutritional plans were considerably out-of-date and had not been reviewed by an appropriately qualified allied professional since being put in place in 2014.
 The Person in Charge has developed a Health Care plan for management of PICA with reflected recommendations and directions by relevant multi-disciplinary allied professionals since April 2022. The Health care plan documents procedures and response plans in line with clinical best practice and recommended emergency response procedures and interventions relevant to the risk posed by consuming an inedible substance.
 PICA risk assessment has been updated.
 The Provider has the Dietician role been advertised as there is vacancy at present. The Person in Charge has support of GP and Director of Clinical Services to monitor diabetic status of Residents through annual medical review and evidence based practice. Diabetic levels are controlled at present. Any anomalies will be addressed by GP till the position of Dietician is filled.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/08/2022
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	30/11/2022
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	31/08/2022

	are consistent with each resident's individual dietary needs and preferences.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/08/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/11/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Not Compliant	Orange	31/08/2022

Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/11/2022
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