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

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| Name of designated centre: | Stewarts Care Adult Services Designated Centre 28 |
| Name of provider: | Stewarts Care Limited |
| Address of centre: | Dublin 20 |
| Type of inspection: | Unannounced |
| Date of inspection: | 27 February 2020 |
| Centre ID: | OSV-0005833 |
| Fieldwork ID: | MON-0028664 |

## About the designated centre

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

Designated Centre 28 is intended to provide full time residential services to no more than eight men with intellectual disability and high support needs. Designated Centre 28 is a two-storey house located on the Stewarts Care Campus in Palmerstown. Each resident has their own private bedroom. There are two communal sitting rooms and dining rooms, a sun room and two kitchens in the designated centre along with two shower rooms, four toilets and an office. Healthcare supports are provided by medical doctors (General Practitioners and psychiatrists) as required. Residents also have access to allied health professionals such as physiotherapists, psychologists, occupational therapists, speech and language therapists and social workers. Nursing supports are available within the designated centre and the centre is staffed by staff nurses and care assistants. The whole time equivalent staffing for this designated centre is 13.4. The staff team are supervised and managed by a full time person in charge.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 8 |

## 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 |
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| Thursday 27 February 2020 | 10:45hrs to 20:20hrs | Louise Renwick | Lead |
| Thursday 27 February 2020 | 12:40hrs to 20:20hrs | Andrew Mooney | Support |

## What residents told us and what inspectors observed

Inspectors met most of the residents who lived in the designated centre and spoke with four residents and a family member. Inspectors spent time observing interactions between residents and staff and the daily activities of the centre.

Inspectors saw that meals were prepared off site in a central kitchen and heated in the small kitchen area in the centre. While food was not prepared or cooked in the centre, there was plenty of food and drinks available for residents. Inspectors saw residents being offered alternatives if they did not wish to have the meal that was on offer and observed staff offering residents drinks and snacks throughout the day.

Throughout the day, inspectors observed some residents watching television in the living room, some residents were spending time in their own bedrooms watching sports or movies and others were spending time with family members that had visited them.

Some residents left the centre independently throughout the day to attend day services or do other things of interest.

In the afternoon some residents were supported to attend a friends home on the campus for a birthday celebration.

Feedback from residents and family members were overall very positive. Residents felt they could go to the staff if they had any concerns or issues, that the centre was comfortable and met their needs. Family members felt they could raise any concern or complaints, and that they would be listened to and things acted upon.

Some residents were unhappy with the delays to their move into different accommodation, which was due to happen by the end of 2019. However, they felt informed about the delay and had regular meetings with the management team who were assisting them. Other residents expressed uncertainty about their peers transition, and how that might change their friendships within the home.

## Capacity and capability

Overall the provider and person in charge demonstrated capacity and capability to operate a good quality of care and support to residents that was safe and meeting their individual and collective needs. This inspection found some areas of non

compliance with the regulations and improvements were required in relation to medicine management, the upkeep of the premises and in the promotion of a rights based approach to care in line with best practice.

There was a clear management structure in place in the designated centre and wider organisation. The person in charge reported to a programme manager. The programme manager reported to the the acting Director of Care of Residents.

There were clear lines of information and escalation regarding this designated centre at the time of the inspection, with regular meetings and reports to the care management team and executive management team on behalf of the provider. Information gathered about this designated centre was being recorded and escalated and used to improve the quality of the care and support being delivered.

The provider had implemented governance oversight systems and processes in order to monitor and improve the quality and safety of care and support across the designated centres. An annual review had been completed by the provider along with six-monthly visits which generated a report and action plan. The last six-monthly audit had been completed in November 2019 and identified actions. For example, reviewing the use of shower curtains in bathroom doorways, and staff knowledge for fire safety. Inspectors found that there was an action plan for all areas identified, some had been achieved, but some remained outstanding.

The improvement plan that was attached to the registration of this designated centre as a registration condition, had not been fully achieved with the time lines indicated in the plan submitted to the Chief Inspector. The provider was in the process of reviewing this improvement plan and had plans to submit an application to vary the registration condition. That being said, some of the actions that had the greatest impact on the experience of residents had been achieved. For example, there was new accessible bathroom in the designated centre. However, other actions for improvement had not been achieved such as preparing and cooking meals at home, the transition of a resident to a different home and residents' access to their own bank accounts.

In general, residents were receiving continuity of care and support from a stable staff team and there were no vacancies for staff roles at present. There was a key worker system in place and residents spent time each month with their key worker. The staff team consisted of  nurses and care assistants. While there was adequate staffing in place during the day time, improvements were required for night time. The statement of purpose and staffing assessment completed by the provider identified a need for two staff to work in the designated centre during the night time. However, inspectors found that the second staff member was absent for over four hours each night in order to cover breaks in other designated centres on the campus. This required attention by the provider to ensure the staffing as assessed was in place at all times. It was also found that one of the night shifts each night were covered by staff not employed to work in the designated centre directly, and there were therefore gaps in the supervision and oversight of these staff by the person in charge.  The staff roster did not clearly reflect who was

on duty at night time.

There were systems in place to identify and provide training to staff members in relevant areas. There was oversight of the training needs of staff and to ensure refresher training was available as required. There was a system of formal and informal supervision in place by the person in charge. Staff had one to one supervision with the person in charge on a quarterly basis. The person in charge was present in the designated centre during the day time, and there were regular staff meetings.

There were arrangements in place to manage complaints, including a specific policy and associated procedures. There was a named person responsible for the management of complaints. It was found that complaints made in the centre were recorded and responded to in line with the provider's policy, and records of measures to address complaints were available for review.

Overall, the provider and person in charge demonstrated that they had the capacity and capability to govern and operate a designated centre that was safe and meeting residents' needs. However, improvements were required in some areas to achieve compliance with the regulations and standards and to promote a more person-centred approach to care and support.

## Regulation 15: Staffing

The management of the staffing resource along with the number of staff available to work in the designated centre required review, to ensure adequate staffing was in place at all times of the day and night.

Nursing care was available in the designated centre, based on the assessed needs of residents.

The planned and actual rosters required improvement to show the actual hours worked including which staff were on duty at night time.

Residents received continuity of care and support from a stable staff team employed to work in the designated centre. There was little to no reliance on temporary agency staffing in this designated centre.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

The provider had arrangements in place for staff in the designated centre to access training, including refresher training. There was an oversight system in place to ensure training needs were identified.

Staff working in the designated centre were appropriately supervised on a day to day basis by the person in charge, along with a formal system of supervision through recorded one-to-one meetings with the person in charge.

Information on the Health Act 2007 (as amended), regulations and standards were available in the designated centre.

Judgment: Compliant

## Regulation 23: Governance and management

There was a clear governance structure in place in the designated centre, along with defined lines of reporting, responsibility and accountability. Staff and residents knew who was in charge and how to raise issues or concerns.

There were effective management systems in place to monitor the safety and quality of the care and support in the designated centre. An annual review had been completed and a schedule of six-monthly visits was in place. The person in charge and senior managers were held accountable for taking action where it was required, and there was oversight of actions from the senior management team and executive team.

The improvement plan that was attached to the registration of this designated centre as a registration condition, had not been fully achieved with the time lines indicated in the plan submitted to the Chief Inspector. The provider was in the process of reviewing this improvement plan and had plans to submit an application to vary the registration condition.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

There was a complaints policy in place dated April 2018 along with easy read versions available in the designated centre.

Residents and family members knew how to raise a complaint and felt comfortable doing so.

A complaint log was maintained in the designated centre for any local complaints,

including what actions were required.

Formal complaints were managed outside of the designated centre, and information on complaints raised through formal processes was not always available in the designated centre. However, records were maintained by the relevant person managing the complaint. The provider's recent audit identified this and actions were being put in place to improve information information locally.

Judgment: Compliant

## Quality and safety

In the past year the provider and person in charge had taken measures to improve the safety and the quality of the care and support for residents living in this designated centre. Inspectors found that in general risk was well managed through an effective process that was guided by a risk management policy. Residents felt safe and were safeguarded and the use of restrictive practices had decreased. Residents' needs were beginning to be re-assessed through improved assessment tools and there was a focus on increasing meaningful activities for all residents. While these were positive findings, further improvements were needed to progress on from the changes already implemented in the designated centre and to now focus on a more person-centred approach to care that was fully promoting residents' rights. Improvements were also required in relation to medicine management, assessments of need and the overall upkeep of the premises.

The designated centre was a two storey building that provided residents with private bedrooms. Each floor had a sitting room with television, a dining area and a small kitchen. Downstairs there was a sun room and access to an enclosed garden area with seating. There were numerous bathrooms in the designated centre. The provider had upgraded a bathroom to ensure all residents could access appropriate facilities for personal care, with a wet room now in place downstairs. Inspectors found that while the premises were comfortable, parts of the centre required some decoration. Two bathrooms within the centre appeared to have inadequate ventilation as there was evidence of excessive condensation which resulted in pealing of paint and a foul odor. The small kitchen did not have sufficient cooking facilities and equipment which hampered the ability for meals to be prepared and cooked at home. There was adequate space for residents to meet with visitors in private if they wished, and family members felt welcome at all times in the designated centre.

Inspectors found that there were effective safeguarding process in place in the designated centre, with clear recording and review of incidents to ensure measures were taken to protect residents from harm. There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions, and the process for responding to and recording safeguarding concerns was in line with national

policy. Residents had access to a social work department, if required, and there was a named designated officer for the designated centre. Inspectors found that safeguarding incidents were screened and responded to appropriately, and if required a safeguarding plan was put in place and additional control measures were implemented to prevent a similar situation from happening again. Staff were knowledgeable on their duties to respond and report any safeguarding concerns and had been provided with training.

There were a range of appropriate fire precautions in place. Staff had received training in fire safety management, and supported residents to engage in evacuation drills. The support needs of residents had been considered in the development of individual evacuation plans, and there was a centre specific plan available also. There was a schedule of maintenance in place for fire safety equipment, including extinguishers and fire blankets. While fire drills had been completed, inspectors found that at night time there was often only one staff present in the designated centre. While evacuation drills demonstrated positive response and good timing to evacuate in the event of an emergency, a practice of evacuation with the lowest amount of staff had not been considered. That being said, the provider had plans in place for support from other areas on campus in the event of a fire through an on call system and this was demonstrated to work effectively in response to emergency situations.

Residents had access to their own general practitioner (GP), and access to this service had improved recently through the introduction of an assessment system prior to an appointment. Residents had access to a range of allied health professionals employed by the provider such as psychology, occupational therapy, clinical nurse specialists and physiotherapy. The person in charge and staff nurses had good oversight of residents' healthcare needs and residents had the choice to avail of national screening programmes if they wished.

Some improvements were required with regards to residents' assessment of needs and personal planning. Residents' healthcare needs were assessed and planned for, information was kept up to date and there was a plan in place for any assessed healthcare need. However, the system of assessing residents' personal and social needs required improvement. The provider had begun to implement a new assessment tool in response to this, and some assessments were being completed. However, these were not fully in place at the time of inspection. The aim of this new tool was to guide staff in identifying residents' individual needs in a more comprehensive manner. On review of a sample of assessments already completed, further improvements were required in relation to how the assessments were used and the plans that were created from their information. The new tool still focused primarily on healthcare and were completed by nursing staff in place of the person's keyworker and circle of support. The sample reviewed did not always adequately assess the needs of residents in known areas. For example, residents who were planning on moving to community based centres and who wished to learn how to cook, did not have this identified through the new tool. The provider was aware that this was a work in progress, and that further training may be required for staff in how to effectively implement and complete assessments

and corresponding personal plans, that were not of a health focus.

The systems for recording and informing residents of activities on their financial accounts required review. Some residents were supported to manage their own personal spending accounts, with appropriate safeguards and skills teaching in place. All residents had accounts in their name that were managed by the provider, from which rent was taken, and their disability allowances were entered. However, residents were not provided with clear records of transactions in and out of these accounts. This hampered the residents' ability to oversee their own finances, and the ability of the person in charge to ensure effective oversight was in place for all transactions completed on residents' behalf.

There was now an improved focus on meaningful activities for residents in the designated centre, with activities identified each day that residents' enjoyed and oversight to ensure these were facilitated. This would be further enhanced through a formal assessment of residents' preferences and abilities and more opportunities to sample new experiences. Some residents had access to formal day services, while others were reliant on the staff team to provide occupation and activity each day. While things were improving in relation to this, more attention was needed to ensure residents had meaningful activation, occupation and stimulation each day, in line with their wishes. Activities were often campus based and residents had not been fully supported to make informed choices about sampling new activities and experiences outside of the designated centre.

Improvements were also required to ensure residents' rights and privacy were fully promoted in the designated centre. Previously, certain control measures were put in place to lower risks in relation to medicine or safeguarding. Now that things had stabilised in relation to risk and safety, these measures were in need of review to ensure they were not institutional in practice. For example, shower curtains were in place across all bathroom doorways to protect residents' privacy, however the person in charge had not considered skills teaching with residents around closing the bathroom door. Similarly, when medicine was being administered there was an overly clinical approach to this by nursing staff, and more person-centred medicine practices had not been considered.

The documentation in relation to medicine management required improvement to ensure the correct dosage and maximum dosage of medicine was documented on prescription records. Inspectors also found that residents who required emergency medicine for epilepsy were not supported to bring this medicine with them if they were outside of the centre. This meant that the medicine could not be used, should an emergency occur when out of the designated centre.

Overall, inspectors found that residents had a comfortable home located on a campus based setting, residents felt safe and they were safeguarded by clear processes. Residents' healthcare needs were identified and well managed and there was now more of a focus on meaningful activities each day. That being said, further improvements were required in relation to the premises, medicine management and risk, residents' general welfare and development and the promotion of residents'

rights.

## Regulation 11: Visits

There were suitable communal facilities to receive visitors in the designated centre.

Residents could receive visitors without any restrictions.

Visitors felt welcome in the centre, and could call at any time to see their relatives / friends.

Judgment: Compliant

## Regulation 12: Personal possessions

Improvements were required to ensure residents had access to clear information in relation to their financial accounts that were managed by the provider.

Residents had their own private bedrooms, with suitable furniture and furnishings in the rooms they occupied.

Residents were supported to retain control over their own clothing and each resident had adequate space to store their clothing and personal possessions and property.

Judgment: Substantially compliant

## Regulation 13: General welfare and development

There was now an improved focus on meaningful activities for residents, with clear recording system and target achievements to promote residents' meaningful activities each day and week. This would be further guided by the implementation of more comprehensive assessments.

There was evidence that residents were encouraged and supported to maintain relationships with their families and natural support networks.

Some residents attended formal day services outside of the designated centre during the day time. For residents without a formal day service, they were reliant on staff to support them with things to keep them occupied during the day time. While

there was an increase in meaningful activities currently, further improvements were required to ensure all residents had access to occupation and activation throughout the day.

Judgment: Substantially compliant

## Regulation 17: Premises

The designated centre was designed and laid out to meet residents' individual and collective needs and were of sound construction.

The matters as set out in Schedule 6 of the regulations were in place, with some improvements required in relation to the following:

- adequate ventilation in two bathroom areas

- General decoration and upkeep in relation to the effects of poor ventilation in the two bathroom areas

- the provision of suitable and sufficient cooking facilities and kitchen equipment

Judgment: Not compliant

## Regulation 26: Risk management procedures

The provider had written and implemented a risk management policy in the designated centre which met the requirements of the regulations.

There was oversight of risk through a well-maintained risk register and risk assessments, and there was an escalation pathway in place.

There was evidence that the service was safe by staff attending to general risk. However, during the inspection inspectors observed excessively high water temperatures within part of the centre. While there had been no incidents of scalding, this had not been considered and assessed through the risk management processes.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

There were established fire safety arrangements in place, including appropriate measures to detect fire, fire fighting equipment and containment measures. Residents took part in planned emergency evacuations drills, and there were individual evacuation plans in place for each resident. There was adequate means of escape including emergency lighting. Staff received appropriate fire prevention and emergency evacuation training.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

The practice relating to the ordering, prescribing, storing, disposal and administration of medicines required improvement.

For example, medicine records did not clearly outline the maximum dosage for all medicines and not all medicine prescribed outlined the exact dosage.

There was an inappropriate practice in place where residents who were prescribed emergency medicine were not always supported to bring it out into the community.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Residents' healthcare needs were assessed and planned for in the designated centre. Assessments were multidisciplinary, and advice from allied health professionals was included in health care plans.

There was an absence of comprehensive assessments of residents' needs to continue to guide the care and support in relation to their personal and social needs and preferences.

Residents' personal plans and care plans were not available to them in an accessible format.

Inspectors found that some residents were supported to learn and develop skills to improve their capabilities and promote independence, such as money management and food preparation. However, this was not standard for all residents and not all residents were assessed in this regard by a suitable professional.

Judgment: Not compliant

## Regulation 6: Health care

Residents had access to a general practitioner (GP) and a multidisciplinary team which consisted of a psychiatrist, psychologists, occupational therapist, physiotherapist, speech and language therapist, clinical nurse specialist in behaviour, social workers and dietitians. Residents also had access to dental services, optician services and chiropody services.

Residents were informed of national screening programmes in an accessible format, and supported to avail of these programmes if they so wished.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Staff had the knowledge and skills to respond to behaviour of concern, through individual behaviour support plans.

Staff were offered training in de-escalation and intervention techniques.

Where required, residents had clear plans in place to guide staff on how to proactively support them in relation to behaviour of concern. There was input from allied health professionals in the creation and review of such plans.

It was noted that restrictive interventions had reduced in the past year. However, further review was required to ensure all environmental restrictions were assessed on an individual basis and reviewed regularly to ensure its necessity. For example, locked storage areas of the designated centre.

Judgment: Substantially compliant

## Regulation 8: Protection

There was a policy in place to guide the management of safeguarding concerns, allegations or suspicions and the process for responding and recording safeguarding concerns was in line with national policy. Where required, safeguarding plans were put in place and monitored by the person in charge.

The provider had appointed a designated officer in the centre to ensure all safeguarding incidents were responded to and investigated, and residents had access to a social work department if required.

Residents had intimate care plans in place to guide their needs and preferences.

Judgment: Compliant

## Regulation 9: Residents' rights

The centre's information governance procedures did not protect residents' privacy. Residents' personal identifiable information was stored in communal spaces.

Certain practices that were put in place previously to lower risk now required review as they were institutional in nature or did not promote a homely environment or person-centred practice.

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 - 2015 as amended and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Substantially compliant |
| Regulation 13: General welfare and development | Substantially compliant |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 29: Medicines and pharmaceutical services | Not compliant |
| Regulation 5: Individual assessment and personal plan | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for Stewarts Care Adult Services Designated Centre 28 OSV-0005833

## Inspection ID: MON-0028664

## Date of inspection: 27/02/2020

**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 | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>There are 2 staff that work night duty in House 24. One staff is placed upstairs to provide support. The 2 men that live upstairs are very independent and come and go from house 24 when they wish.<br>If and only when required this staff member would cover staff breaks in some homes on campus. They also support personal care in 3 different homes through the night.<br><br>They may be required to support a house if a service user requires to attend hospital at night or staff member becomes unwell during the night.<br>They also support the areas around campus with fire evacuation or emergencies at night.<br>Last July when the DNAs had been reviewed by the register provider it was deemed that the DNA within House 24 was deemed accurate in providing continuity of care and support day and night.<br><br>The night time staff who had been under the governance of the ADON nights will now transfer to the roster of the center. This person will now be under direct supervision of the Person In Charge of the center and will be listed on the centers rosters providing clarity to staffing levels for day and night. This has come into effect on the 14/04/2020 | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management: | |

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| Review of compliance plan to be completed before 30th June with an application to vary the registration condition. |

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| Regulation 12: Personal possessions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The information regarding resident's monthly financial statements will be conveyed on a newly developed template supporting residents to understand transactions to and from there accounts, the reason for the transactions and their monthly opening and closing balance.
The residents will be provided with an opportunity when applicable through their keyworker to discuss and ask questions about their finances and monthly statements. The template will be in easy read format and is currently being developed.

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|---|---|
| Regulation 13: General welfare and development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The assessment of need was developed and put into circulation in January 2020 with all areas to have completed this assessment with their residents before the 31st of March. This assessment will then be reviewed over the coming months. House 24 are currently incorporating additional information within the assessment around daily occupation/community supports focusing on PATH goals developed for each resident.

Further support will be provided to the area on a weekly basis by 2 appropriately qualified staff members. This support will focus on the development and implementation of a person centered educational and personal development programme for each of the residents. This will focus on developing skills around finances and everyday tasks. This will take place before 30th June.

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| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
The ventilation system in the bathroom areas is being reviewed by the maintenance department with a view to improving its function with subsequent improvement in general decoration of bathroom areas. Downstairs bathroom is brand new.

Cooking facilities in place in house 24 include oven, cooker/hob, microwave, pots, pans, utensils, blenders, toaster, soup maker and sandwich maker.

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| Regulation 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Temperature of water has been reviewed by technical services and reduced to a safe level on the 28th February.

A risk assessment has been created which includes the checking and recording of the temperature of the water coming from the tap to ensure it remains at a safe level 20th April.

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| Regulation 29: Medicines and pharmaceutical services | Not Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The practice relating to the ordering, prescribing, storing, disposal and administration of medicines have been reviewed in the area. 2 GPs work on campus Monday to Friday and are satisfied that the ordering of medication and storing of medication is satisfactory. The person in charge has completed a review of the administration of medication in the area and this follows all required steps within the administration of medication policy in Stewarts care.

All residents that have epilepsy and rescue medication have health care plans to guide staff. If there is no nurse or SAMS trained staff available when out on a social outing they contact emergency services. There would not always be staff available to administer rescue medication while on outings. If only staff nurses or SAMS trained staff was to accompany residents with epilepsy on social outings then residents would have very little access within the community. There is an ongoing review of the number of SAMS trained

staff in all homes with a review to increase SAMS trained staff within the organization before July 31st.
All resident that do go on outings who have epilepsy are risk assessed on the frequency they would require rescue medication. Resident 305 has not required rescue medication since epilepsy records in their personal support plan was developed in 2013.

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|---|---|
| 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:
The format with which the organization currently assesses the person's personal and social needs is under review. The aim of the review is to ensure these areas are assessed and actioned in a comprehensive manner. The actions generated by the assessments will be carried out by the persons Allied Health Care team under the governance of the Person In Charge.

Further support will be provided to the area on a weekly basis by 2 appropriately qualified staff members. This support will focus on the development and implementation of a person centered educational and personal development programme for each of the residents. This will take place before 30th June. This will then be further enhanced through the keyworkers and their involvement in the assessment of need through their responsibility and actions completed.

Personal plans/care plans in an accessible format are currently been developed in House 24 and will be completed by the 30th June.

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| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The practice of locked storage areas is currently under review. These are being risk assessed based on the individual needs of each resident. Where it is found the risk is at an acceptable level these storage areas will be opened and the risk level monitored. Where it is found a level of unacceptable risk remains the practice will be examined for ways of reducing this risk based on individual needs. This process will be reviewed on a regular basis by the Person In Charge in line with the principle of least restrictive for the least amount of time. Members of the risk management team will be consulted

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| throughout the process. |

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| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Peron In Charge has reviewed how resident's personal information is stored, particularly in communal areas. Where the processes are found not to meet the regulations the PIC will ensure alternative methods are developed and implemented to do so before 30th May.
Risk management procedures in the area are under review and being assessed with a view to reducing institutional practices where appropriate. For example the practice of using curtains across bathroom doors has now been discontinued with support being given to residents in this area when required.

## 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 |
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| Regulation 12(1) | The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs. | Substantially Compliant | Yellow | 30/06/2020 |
| Regulation 13(2)(a) | The registered provider shall provide the following for residents; access to facilities for occupation and recreation. | Substantially Compliant | Yellow | 30/06/2020 |
| Regulation 13(2)(b) | The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with | Substantially Compliant | Yellow | 30/06/2020 |

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| | their interests, capacities and developmental needs. | | | |
| 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. | Substantially Compliant | Yellow | 30/04/2020 |
| Regulation 15(4) | The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained. | Substantially Compliant | Yellow | 30/04/2020 |
| Regulation 17(1)(c) | The registered provider shall ensure the premises of the designated centre are clean and suitably decorated. | Substantially Compliant | Yellow | 30/06/2020 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 18/04/2020 |
| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated | Substantially Compliant | Yellow | 26/05/2020 |

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| | centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | | | |
| 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 | 30/04/2020 |
| Regulation 29(4)(b) | The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the | Not Compliant | Orange | 18/04/2020 |

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| | resident for whom it is prescribed and to no other resident. | | | |
| 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. | Not Compliant | Orange | 30/06/2020 |
| Regulation 05(5) | The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative. | Substantially Compliant | Yellow | 30/06/2020 |
| Regulation 07(4) | The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice. | Substantially Compliant | Yellow | 18/04/2020 |
| Regulation 09(3) | The registered provider shall | Substantially Compliant | Yellow | 30/05/2020 |

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| | ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information. | | | |