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 19
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	06 November 2019
Centre ID:	OSV-0005853
Fieldwork ID:	MON-0027123

About the designated centre

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

Designated Centre 19 provides long stay residential care and support to up to eight adult women with complex support needs. The centre is comprised of a large bungalow, located in the providers campus in Dublin, which contains numerous designated centres and facilities such as catering, laundry and day services. The bungalow is wheelchair accessible, and contains eight bedrooms, a small kitchen, and ample communal space. It is located in close proximity to local amenities, transport links and community facilities. The centre aims to provide a comfortable home that maintains and respects independence and well being, and provides a high standard of care and support in accordance with evidence based practice. The person in charge is a social care worker, and care and support is provided by a team of nurses and health care assistants.

The following information outlines some additional data on this centre.

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
Wednesday 6 November 2019	09:30hrs to 17:30hrs	Amy McGrath	Lead

What residents told us and what inspectors observed

The inspector met with all eight of the residents who lived in the centre. Some of the residents spoke to the inspector with support from staff. Some residents, with alternative communication methods, did not share their views with the inspector, and were observed throughout the course of the inspection in their home.

The inspector observed some interactions between staff and residents to be person-centred, friendly and considerate. Some conversations between staff and residents indicated that staff knew and understood residents' care and support preferences. Communication at meal times was observed to be friendly and encouraging, although brief and often directive due to inadequate staffing levels. Staff supported residents to eat their meals, and facilitated any specialist recommendations for residents during these times. However, the higher support needs of some residents, who for example needed constant staff supervision to manage the risk of choking, meant that staff were limited in how much time they could spend with each person. Mealtimes appeared to be rushed, although all interactions were observed to be cheerful, and staff attempted to facilitate choice where possible.

It was observed that residents spent a large portion of the day in the centre, with little planned activities or engagements. A number of residents spent most of the day (outside of meal times) watching television in a living area. One resident went to visit a relative in another house on the campus. Another resident communicated that they would like to go out at this time, and became upset as this could not be facilitated. The inspector observed staff blocking a door to ensure this resident did not leave the premises. Shortly after, staff supported this person to visit the organisation's café for a coffee.

Overall, the inspector observed some person centred care being delivered by staff, however the level of support required by residents, coupled with staff limitations (including off-site break times) meant that this was not consistently delivered. Residents were seen to spend most of their day having basic care needs met, and minimal meaningful activity or engagement.

Capacity and capability

The governance and management arrangements had not ensured a safe and good quality service was being delivered to residents. The provider had not ensured that the oversight mechanisms in place were facilitating required change to deliver a safe and quality service. While there were numerous audits and reports on the quality of care carried out, the findings of these audits had not informed necessary action to provide quality care to residents. Furthermore, it was found that the centre

was insufficiently resourced to provide appropriate care to residents.

Prior to this inspection information was received by the Chief Inspector of Social Services that highlighted concerns regarding the quality of care provided at the centre. This inspection was carried out to review the matters that were raised.

The inspector reviewed the progress of an improvement plan which is to be implemented as a restrictive condition of registration. It was found that some of the actions had not been implemented in the time frame submitted by the provider, including a delay to the implementation of a comprehensive assessment of need, and actions required in relation to the premises.

It was found that the staffing levels were insufficient to meet the needs of all residents. There had been a reduction in staffing since the previous inspection, and this had resulted in a significant reduction to the quality and safety of care received by residents. This issue had been raised to the provider through various internal monitoring systems, including internal audits and safeguarding concerns, however the provider had failed to adequately address the issue.

The decision, by the provider, to remove a day activation staff had impacted on opportunities for residents to engage in meaningful activities, both in and outside of their home. It was found that residents rarely left the campus, and infrequently participated in activities or opportunities for leisure in the community.

A review of daily notes, and discussions with staff, found that the centre was inadequately resourced to respond to the needs of residents in a timely and dignified manner. While the staff employed in the centre were sufficiently qualified, and knowledgeable of the care and support needs of residents, they were limited in their ability to provide quality care to residents due to inadequate staffing levels.

The centre was home to eight residents, some of whom required two support staff to access the community, bathe, or get in and out of bed. A number of residents required the use of a wheelchair in their home, and most residents used a wheelchair when outside of their home. Three health care assistants and one nurse worked in the centre on a daily basis, with one staff on duty overnight. This staffing resource for the centre was inadequate, not only in facilitating choice and participation of residents in their care, but in meeting residents' needs in a timely and person centred manner.

The inspector found that during busy times of the day (for example mornings, staff breaks, and meal times), restrictive practices were relied upon to manage risk of absconding for one resident. During these periods, there were limitations in how staff could respond to the care needs of each resident due to supervision needs. While there had been some effort made at a local level to minimise the impact to residents, it was insufficient to address the severity of the issue.

In one instance, it was recorded that a resident chose not to get out of bed in the morning, or at later times when staff offered support; however at various times later and throughout the day the residents request to get up could not be facilitated due to staff being busy. Daily notes indicate that this person asked for support to

shower in the evening, and was advised to wait for the next opportunity in the 'bathing schedule'. Furthermore, at 7pm this resident asked again to get up from bed, and staff informed them it was now too late, and advised getting up early the next morning. This resident remained in bed for a period of over 36 hours.

The inspector was not satisfied that the staffing levels were appropriate to meet this persons needs in a responsive manner. It was evident that residents care and support was guided by resources and not by the resident themselves.

There was a planned roster available that identified the proposed staffing arrangements on a weekly basis. There was also an actual roster, and while it reflected changes to the planned arrangements, it did not identify the specific staff members working on a day-to-day basis. The provider had arranged for relief or agency staff to cover some staff absences, although nursing shifts were not consistently covered by nursing staff, and while the provider had identified this as a risk and implemented risk management measures, it was found that they were not providing nursing care as outlined in their statement of purpose.

Improvements were required to ensure that staffing arrangements provided continuity of care for residents. On the day of inspection, two of the four staff working were agency staff, one of whom had never worked in the centre before. The inspector also noted a staff member on duty during the inspection did not know the names of residents who lived in the centre.

The person in charge carried out a range of internal audits, and had regular supervisory meetings with the programme manager. The findings of audits and review of information such as incidents and health care needs, were then reported to a senior care management team on a monthly basis. It was found that the person in charge and staff had reported concerns regarding the resources within the centre on numerous occasions. The providers own six-monthly unannounced visit also identified areas requiring improvement to ensure that residents received a person centred, good quality service, including concerns regarding residents choice of bedtime. It was found that concerns escalated to management had not been appropriately addressed.

All required records were maintained and available for inspection. The person in charge had ensured that local records were well maintained, including records of staff meetings and supervision. There was a residents guide available for residents, as well as a statement of purpose and copies of previous inspection reports.

All events and incidents, that require notification to the Chief Inspector of Social Services had been notified appropriately, and within the required time-frame.

There was a complaints policy in place, including an accessible complaints procedure, and staff had supported residents to make complaints at various times. There were accurate records maintained of complaints made, however there was no record of any response to residents, level of satisfaction of the complainant, or evidence that efforts had been made to resolve complaints. Overall, it was found that complaints were not being managed in accordance with the providers own

policy.

Regulation 15: Staffing

The inspector found that there was insufficient staffing to meet the needs of residents. There was a planned and actual roster, which was maintained by the person in charge, however at the time of inspection this did not accurately identify the staff members on shift. There were minimal staffing vacancies identified by the provider, and there were arrangements in place to ensure planned staffing levels were maintained, with the use of relief or agency workers. However there were occasions that staffing levels were below the minimum identified by the provider, and nursing staff was not always provided as per the statement of purpose.

The assessment of need that informed staffing levels was not based on the comprehensive needs of each resident, and as such, the staffing arrangements were inadequate in meeting residents needs in a safe and planned manner.

Judgment: Not compliant

Regulation 21: Records

Records were maintained and available for inspection, and were found to be accurate and up to date. Records such as statement of purpose, residents guide and inspection reports were available for staff and residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents were notified within the required time frame and that all necessary information was submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and accessible procedure in place. Residents were supported to make complaints about the service, however, while they were escalated to a designated complaints officer, there was no evidence that complainants were responded to.

Judgment: Not compliant

Regulation 23: Governance and management

The centre was not adequately resourced to meet the needs of residents, or to deliver care and support in accordance with the statement of purpose.

While there were clear lines of authority and accountability, it was found that the governance and management arrangements were not ensuring that the service received by residents was safe and of good quality. Furthermore, the systems in place were not facilitating staff to exercise their professional responsibilities, with limited resources impacting on the quality of service provision.

There were reporting mechanisms in place, including a range of audits and reviews, however information from these reviews was not being utilised to effect necessary change. There had been concerns raised regarding the standard of care provided in the centre, and these had not been appropriately addressed.

The inspector found that the provider had not carried out a number of actions from an improvement plan (implementation of which is a condition of registration) within the proposed time lines.

Judgment: Not compliant

Quality and safety

The governance and management arrangements in the centre did not support the provision of safe and quality care. While there were some good practices observed at a local level, the quality of care was significantly impacted by inadequate resources and institutional practices. The inspector found that the provision of care was largely task-led, and did not uphold residents individual rights, or adequately meet their health, social and personal needs.

Significant improvement was required to ensure that each resident was provided with appropriate care and support, in accordance with their assessed needs and preferences. It was found that access to facilities for leisure and recreation were extremely limited. The centre accommodated eight women, none of whom attended a day service, or were engaged in regular planned meaningful activities. A review of

daily notes, and discussion with staff found that two residents attended the gym (located on campus) on a weekly basis, and any other activities were heavily dependant on staffing levels.

All residents required staff support to access the community, and a number of residents required two staff to engage in activities outside of their home. Records indicated there was a maximum of two hours in the afternoon where there was sufficient staff to facilitate a resident leaving their home. This meant that residents rarely left the campus, and outings or activities were primarily trips to other centres (to visit friends) or to the café on campus. Some residents were occasionally supported to go to the local shop or restaurant, and staff told the inspector how some residents went to a birthday party in a hotel the week previous. Staff acknowledged that this was not typical, and required significant planning and good will of staff.

Residents had been supported to make complaints to the provider regarding staffing levels and availability of leisure facilities, including dissatisfaction with a reduction in frequency of therapeutic interventions (such as lymphatic massage) and missed opportunities due to staffing levels. It was not evident that these complaints had been responded to.

Residents were not supported to develop relationships or links in the wider community, and that while there were some campus based facilities available (when resources allowed use of same), residents did not have opportunities to participate in activities in accordance with their interests and developmental needs.

There were communication support plans in place for each resident. There were plans in place to carry out communication assessments for residents, however at the time of inspection, the person in charge had developed individual plans based on available information, and these were found to inform communication with residents. While it was evident that residents communication needs were better understood by regular staff, there was sufficient information available to new or temporary staff to ensure that residents could make their views known. Residents had access to a television and radio, and while there was limited Internet access available, at the time of inspection no resident was using the Internet for their own personal reasons.

The health care needs of residents had been comprehensively assessed, and each resident had attended an annual medical review in the last 12 months. There were clear personal plans in place for any identified health care need, and these incorporated recommendations of specialists where applicable. Residents had access to a general practitioner service, and a range of allied health professionals. Health care plans were found to be guiding delivery of responsive health care support.

Prescribed medicines were dispensed by a local pharmacy, and found to be appropriately stored. There was a range of medication audits in place that ensured medicines were safely received, stored and dispose of. Residents medication was administered by a staff nurse, or a staff member with appropriate training. There were guidance documents in place to ensure that medicines were administered as

prescribed, and for the most part these were accurate and sufficiently detailed. It was found in the case of one resident, that guidance regarding administration of emergency medication was inaccurate.

There were arrangements in place to protect residents from the risk of abuse, including an organisational policy and clear procedures. There was an identified designated officer, and it was found that concerns or allegations of potential abuse were investigated and reported to relevant agencies. While there had been a number of safeguarding investigations carried out, it was found that were active risks in relation to institutional abuse that were not subject to safeguarding plans. A review of safeguarding plans, and records of safeguarding meetings found that while there had been measures implemented to minimise immediate safety risks (such as risk of not receiving medication, or risk of falls), there were no plans in place to address the impact of institutional care practices on residents quality of life. It was identified in correspondence that concerns regarding 'individualised' services could not be addressed due to resource issues.

The inspector found that there were inadequate mechanisms in place to uphold residents rights, and that arrangements in place did not support residents to exercise their rights as individuals, or ensure that complaints were heard and responded to. Residents had limited opportunities to make choices about their care, or how they spent their day. Residents' views were not considered in decision making processes, and it was found that decisions about how support was delivered were resource led, and not guided by residents needs or preferences.

Residents support needs had been assessed with regards to their health care, bathing and eating support requirements. This was not comprehensive however, the assessment did not consider residents individual rights or comprehensive personal and social needs. For example, residents could not decide their own bedtime, as sufficient staffing was not available after 8pm to support each resident to get into bed. While staff made efforts to facilitate individual preferences regarding bathing, it was found in some cases that personal preference could not be facilitated due to resources and schedules.

Residents had access to advocacy services, however concerns raised via independent advocacy services were not adequately addressed.

The inspector found that residents did not have ownership of their own finances, and that support provided was not in line with residents assessed needs and preferences. Residents finances were managed by the organisation, and residents received sums of their own money at planned intervals. Additional requests for their own money needed to be made in advance, with information regarding its proposed use. It was found that the provider had failed to implement an action within their improvement plan in relation to residents finances, and none of the residents in the centre had their own bank account.

The design and layout of the premises was generally suitable to meet residents basic needs. The provider had identified that some of the bedrooms were quite small, although there was no plan in place to address this. There were some actions

outstanding from the providers improvement plan, including painting (there were numerous patches of exposed plaster in living areas) and the installation of laundry equipment. It was found that residents did not have access to facilities to launder their own clothes, and laundry was outsourced to the campus laundry service. The garden was inaccessible to residents, as it could not be safely accessed by a wheelchair. This had first been raised to the provider in 2015 but had not yet been addressed at the time of this inspection.

The provider had submitted in their improvement plan that a minimum of two meals per week would be cooked in the centre by January 2019. At the time of inspection, meals were prepared and delivered by the campus catering service daily. There were insufficient facilities to prepare and cook meals for eight people. The kitchen contained a microwave and equipment to reheat food delivered by the catering service, but did not have an oven or hob, or necessary cooking equipment. It was also found that there was insufficient staffing to facilitate the preparation and cooking of meals, as this would have taken from staff delivering necessary care and support to residents. The inspector found that staff had requested a soup maker to support residents choices at lunch time, and this had been purchased in the previous month and had been used occasionally.

Overall, it was found that while there was adequate and nutritious food available, the arrangements in place did not represent genuine choice or participation. Residents were not supported to prepare and cook their own food, had limited access to the kitchen area, and meal choices were based on a predetermined rotational menu. Residents meal times were also restricted to facilitate staff breaks.

The inspector acknowledges that there were efforts made at a local level to offer choice to residents, and that there were frozen meals available as alternatives.

Regulation 10: Communication

Residents were supported to communicate using preferred methods. There were plans in place for a comprehensive review of communication support needs of residents, and at the time of inspection there were detailed plans in place that utilised the most current assessment, and staff and family knowledge.

Judgment: Compliant

Regulation 12: Personal possessions

The inspector reviewed the progress of the providers improvement plan in relation to supporting residents to manage their own money. It was found that residents did

not have access to personal banking services, and received their money from the organisations accounts department by ordering in advance. It was found that the provider had not implemented the actions within the improvement plan within the proposed time frame.

Judgment: Not compliant

Regulation 13: General welfare and development

There were inadequate arrangements in place to facilitate residents with opportunities for occupation, education or recreation. Residents had minimal opportunity to engage in leisure activities outside of their home or the service campus. There were no plans, or adequate facilities in place to support residents personal development.

Judgment: Not compliant

Regulation 17: Premises

The design and layout of the premises was adequate to meet residents needs, although the provider had identified that some bedrooms were very small. It was observed that the garden was inaccessible to residents who used wheelchairs, and as such could not be used by residents. This issue had been raised to the provider for a number of years, and had not been addressed.

Some areas of the premises required painting. There was no access to laundry services within the house, and there was insufficient equipment to prepare and cook meals.

Judgment: Not compliant

Regulation 18: Food and nutrition

There was adequate nutritious food available to residents, however this continued to be provided by a central kitchen with a planned rotational menu. Residents had limited opportunities to shop for, prepare and cook their own meals.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents guide that contained the required information as set out in the regulations.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were found to be ordered, received and stored appropriately. Residents' medicines were prescribed by appropriate medical professionals, and dispensed by a pharmacist. For the most part, there were suitable arrangements in place to ensure that medication was administered as prescribed, however guidance for the usage of PRN (medicine to be taken as the need arises) medication for one resident was found to contain inaccurate information and required review.

Judgment: Substantially compliant

Regulation 6: Health care

Residents health care needs were comprehensively assessed, with detailed care plans in place. Resident health care needs were met in a planned manner, and they had access to a general practitioner and a range of allied health professionals.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to safeguard residents from the risk of abuse, and identified concerns or allegations were investigated appropriately by a designated officer. There were safeguarding plans in place for residents following identification of risks, however at the time of inspection there was evidence that the risk of potential institutional abuse had not been adequately addressed. It was found that residents were experiencing reduced quality of care with insufficient staffing, rigid routines, and limited choice.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that while staff members treated residents with dignity and respect, residents' rights were not being consistently upheld. There were minimal opportunities for residents to make choices and contribute to decisions about their care. While there was information available in relation to advocacy services, with some residents accessing an external independent advocate, the inspector found that this had not facilitated residents to assert their rights to challenge decisions which resulted in restriction of opportunities.

Residents were not supported to exercise their civil and legal rights; there were restrictive practices in place to prevent residents from leaving the premises in the absence of adequate staffing levels, and institutional practices and limited resources had resulted in limited opportunities for residents to leave their home, or make choices about how they spent their day. Residents finances continued to be managed by the organisation, and residents were required to make requests for their own money and provide detail of proposed purchases for approval. It was found that there were practices in place that did not respect residents capacity to make decisions, both on a day to day basis, and in relation to their long term care.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 19 OSV-0005853

Inspection ID: MON-0027123

Date of inspection: 06/11/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The number of staff in the designated centre was reviewed at the Dependency Needs Assessment Review Group on 4/12/19 to ensure that the numbers of staff in the designated centre is sufficient to provide a safe service. Where an individual's needs changes, a business case will be developed and submitted to the Director of Care-Residents for the Director of Care-Residents to review and submitt to the HSE for approval. 2. The vacancies in the designated centre are as follows: 1.34 care staff. A full-time care staff is due to commence in the designated centre on the 16/12/2019. The person in charge shall ensure accurate actual rosters are maintained (30/11/19).	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: 1. The pathway for complaints will include acknowledging receipt of the complaint immediately. Complaints will be resolved within the timeframes as per the policy (28 working days) and if they cannot be resolved within the timeframes, updates will be provided on the progress. If the complaint cannot be resolved to the satisfaction of the complaint, an internal review will take place (27/11/2019). The complaints policy will be updated to reflect this change (31/12/2019).	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The number of staff in the designated centre was reviewed at the Dependency Needs Assessment Review Group on 4/12/19 to ensure that the numbers of staff in the designated centre is sufficient to provide a safe service. Where an individual's needs changes, a business case will be developed and submitted to the Director of Care-Residents for the Director of Care-Residents to review and submit to the HSE for approval.
2. The vacancies in the designated centre are as follows: 1.34 care staff. A full-time care staff is due to commence in the designated centre on the 16/12/2019.
3. The compliance plan will be reviewed to provide updates and realistic timelines and submitted to the Authority (31/12/2019)
A registered provider visit took place in the designated centre (13/11/2019)

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
1. The registered provider shall continue to establish mechanisms for residents to set up their own bank accounts. The person in charge shall also endeavour to support residents to access their own bank accounts. (31/03/2020)
The compliance plan will be updated with details of progress to date and revised timelines and submit to the Authority (31/12/2019)

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. A review of the access to recreation facilities on campus will take place with a view to reopening services. (31/01/2020)
2. A review of staffing levels will take place to consider residents access to activities in accordance with their interests, capacities and needs (28/02/2020)
Resident's opportunities for accessing activities of their choice and preference shall be

recorded and reviewed by the Person in Charge with targets measured against key performance indicators. These shall be reviewed at monthly team meetings (30/11/2019).

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. The garden will be redesigned to make it accessible to residents (30/09/2020) 2. The laundry facilities will be provided (30/09/2020) 3. Areas requiring painting will be painted (30/09/2020) Cooking facilities will be provided (30/09/2020)	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: 1. Where residents buy, prepare or cook their own meals, this will be recorded at the residents meetings. 2. A review of staffing levels will take place to consider facilitating residents to buy, prepare and cook their own meals will take place (28/02/2020). Union discussions will continue to promote staff moving towards supporting residents to buy, prepare and cook their own meals (30/06/2020).	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: 1. The guidance for the PRN administration of one medication for one resident shall be updated (08/11/2019)	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: 1. There is a designated officer in the centre with responsibility for investigating incidents of potential abuse. Where there is a concern of institutional abuse, the Designated Officer will convene a safeguarding meeting. The Principal Social Worker will act as DO and complete a PSF1 citing institutional abuse. This will be then escalated to the Executive Management Team The Restrictive Practices Committee reviewed all restrictions in the designated centre on the 20/11/2019. The restrictions will be reviewed again on the 08/01/2020.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: 1. A review of the weekly service user meetings will take place to ensure they are meaningful for the residents (30/11/2019) 2. A review of staffing levels will take place to consider residents access to activities in accordance with their interests, capacities and needs (28/02/2020) Staff will be trained on person centred practices (31/03/2020)	

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 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.	Not Compliant	Orange	31/03/2020
Regulation 12(3)(b)	The person in charge shall ensure that each resident is supported to manage his or her laundry in accordance with his or her needs and wishes.	Not Compliant	Orange	30/09/2020
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with	Not Compliant	Orange	28/02/2020

	evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.			
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	30/01/2020
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	28/02/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/11/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	04/12/2019

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	30/11/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/12/2019
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	30/11/2019
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	Substantially Compliant	Yellow	30/09/2020

	externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/09/2020
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/09/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2020
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Not Compliant	Orange	28/02/2020
Regulation 18(4)	The person in charge shall ensure that residents have	Substantially Compliant	Yellow	30/11/2019

	access to meals, refreshments and snacks at all reasonable times as required.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	04/12/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and	Substantially Compliant	Yellow	30/11/2019

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/12/2019
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 resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	30/11/2019
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/12/2020
Regulation	The registered	Not Compliant	Orange	31/12/2019

34(2)(d)	provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.			
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/12/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/11/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/11/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Not Compliant	Orange	28/02/2020

	and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Orange	28/02/2020
Regulation 09(2)(e)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability is consulted and participates in the organisation of the designated centre.	Not Compliant	Orange	28/02/2020